CCME

South Carolina External Quality Review

COMPREHENSIVE TECHNICAL REPORT FOR CONTRACT YEAR '20-21

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Prepared on behalf of the
South Carolina Department
of Health and Human Services

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EXECUTIVE SUMMARY

The Balanced Budget Act of 1997 (BBA) requires State Medicaid Agencies that contract with Managed Care Organizations (MCO) to evaluate their compliance with state and federal regulations in accordance with *42 Code of Federal Regulations (CFR) 438.358*. To meet this requirement, the South Carolina Department of Health and Human Services (SCDHHS) contracted with The Carolinas Center for Medical Excellence (CCME), an external quality review organization (EQRO), to conduct External Quality Review (EQR) for all managed care organizations (MCOs) participating in the Healthy Connections Choices and Healthy Connections Prime Programs. The MCOs include:

- Absolute Total Care (ATC)
- Healthy Blue
- Humana Healthy Horizons (Humana)
- Molina Healthcare of South Carolina (Molina)
- Select Health of South Carolina (Select Health)
- WellCare of South Carolina (WellCare)

CCME also conducted EQR for SC Solutions, a primary care case management program providing care coordination for the Medically Complex Children's Waiver program.

The purpose of the external quality reviews was to ensure that Medicaid enrollees receive quality health care through a system that promotes timeliness, accessibility, and coordination of all services. This was accomplished by conducting the following activities: validation of performance improvement projects, performance measures, and surveys; review for compliance with state and federal regulations; and provider access studies for each MCO. This report is a compilation of the findings of the annual reviews conducted during the 2020 - 2021 review cycle and a summary of the readiness review conducted for Humana.

A. Overall Findings

Federal regulations require MCOs to undergo a review to determine compliance with federal standards set forth in *42 CFR Part 438 Subpart D* and the Quality Assessment and Performance Improvement (QAPI) program requirements described in *42 CFR § 438.330*. Specifically, the requirements are related to:

- Availability of Services (§ 438.206, § 457.1230)
- Assurances of Adequate Capacity and Services (§ 438.207, § 457.1230)
- Coordination and Continuity of Care (§ 438.208, § 457.1230)

- Coverage and Authorization of Services (§ 438.210, § 457.1230, § 457.1228)
- Provider Selection (§ 438.214, § 457.1233)
- Confidentiality (§ 438.224)
- Grievance and Appeal Systems (§ 438.228, § 457.1260)
- Sub contractual Relationships and Delegation (§ 438.230, § 457.1233)
- Practice Guidelines (§ 438.236, § 457.1233)
- Health Information Systems (§ 438.242, § 457.1233)
- Quality Assessment and Performance Improvement Program (§ 438.330, § 457.1240)

To access the health plan's compliance with the quality, timeliness, and accessibility of services, CCME's review was divided into seven areas. The following is a high-level summary of the review results for those areas. Additional information regarding the reviews, including strengths, weaknesses, and recommendations, are included in the narrative of this report.

Administration

42 CFR § 438.224, 42 CFR § 438.242, 42 CFR § 438, and 42 CFR § 457

The Administration section covered the standards on policies, staffing levels, compliance, information systems, and confidentiality. The 2020 - 2021 EQRs for ATC, Healthy Blue, Molina, Select Health, and WellCare concluded that each health plan's general approach to the development, maintenance, and review of policies and procedures was consistent with the *SCDHHS Contract* and federal regulations.

Each plan's Organizational Chart documents sufficient staffing coverage to meet each department requirements for contractually designated roles. The organizational structure and lines of communication are clearly defined in detail in company department manuals, staff and member handbooks, and program descriptions.

Plan Compliance Committee charters, committee minutes, compliance plans, and the role of the Compliance Officer was evident for each health plan reviewed. Lines of communication regarding the reporting of fraud, waste, and abuse (FWA) were evident. Training and education about general compliance policies and ethics attestation was found to be a collaborative effort between plan Human Resources and the Compliance Departments. Each health plan has in place policies specific to confidentiality, which stipulate that all associates, during business operations, have a responsibility for the use and disclosure of member Protected Health Information.

The Information System Capabilities Assessment (ISCA) documentation provides a clear overview of systems, processes, and polices that are in place to service the *SCDHHS Contract*. The MCOs

process provider claims in an accurate and timely fashion. The organizations' security plans contain bolstered policies and procedures that address the tasks necessary to maintain that security posture. The plans have disaster recovery and business continuity plans to ensure data systems are operational in the event of an outage. Policies and procedures aligned with *42 CFR § 438.242* and appear to be frequently reviewed and updated based upon each document's change log timestamps.

Provider Services

42 CFR § 10(h), 42 CFR § 438.206 through § 438.208, 42 CFR § 438.214, 42 CFR § 438.236, 42 CFR § 438.414, 42 CFR § 457.1230(a), 42 CFR § 457.1230(b), 42 CFR § 457.1230(c), 42 CFR § 457.1233(a), 42 CFR § 457.1233(c), 42 CFR § 457.1260

Each of the health plans has policies and procedures detailing provider credentialing and recredentialing processes and have established committees that use a peer-review process for credentialing and recredentialing determinations. During the previous review, several issues were identified with health plan documentation of credentialing and recredentialing processes. The health plans adequately addressed the findings in response to the Quality Improvement Plan (QIP). Credentialing and recredentialing files reviewed during the most recent EQRs revealed several issues related to querying the Social Security Administration's Death Master File (SSDMF), verification of Clinical Laboratory Improvement Amendments (CLIA) certification, and documentation of queries of exclusion and sanction databases. For the previous EQR, identified issues were related to lack of evidence of required queries, incomplete provider applications, missing CLIA verifications, outdated Ownership Disclosure forms, untimely primary source verification, and outdated nurse practitioner collaborative agreements. The applicable health plans addressed the specific findings in response to the QIPs.

Based on a review of health plan policies and procedures, all the MCOs comply with provider access standards and have processes for monitoring the networks' abilities to meet membership needs. When reviewing health plan reports of network assessments for the most recent EQRs, issues identified included failure to include all required Status 1 provider types in Geo Access reporting (ATC and Molina) and discrepancies in documentation of provider access standards (Select Health). This was a repeat finding for ATC from the previous EQR. For the most recent EQRs, standards and requirements for PCP and specialist appointment access were defined in health plan policies and/or procedures. ATC's and WellCare's documentation was compliant with access standards defined in the *SCDHHS Contract, Section 6.2.2.3*; however, issues were noted with the remaining plans' documentation of appointment access standards. Select Health had a repeat finding from the previous year's EQR. The MCOs have established Cultural Competency programs to ensure network providers can serve members with special needs.

CCME evaluated the MCOs' Provider Directories for compliance with state and federal requirements. For ATC and Healthy Blue, recommendations were given for revisions to improve

minor issues noted in the Provider Directories. For Molina, a QIP was implemented for two required elements that were not included in the Provider Directory.

As a part of the annual review process for all plans, CCME performed a Telephonic Provider Access Study focusing on PCPs. From each plan's submitted list of network providers and contact information, CCME defined a population of PCPs and selected a statistically relevant sample of providers for the study. CCME attempted to contact these providers to ask a series of questions about the access plan members have to their PCPs. One plan (ATC) received a score of "Met" and the other four plans received a score of "Not Met" for the standard requiring an improvement in the results of the Telephonic Provider Access Study.

Established policies and procedures guide MCO initial and ongoing provider education activities. Several issues were identified that resulted in recommendations and/or QIPs for the health plans related to education about appointment access standards (ATC), copayments for members in waiver services and medical record documentation standards (Healthy Blue), and member benefit information (WellCare).

Preventive Health Guidelines (PHGs) and Clinical Practice Guidelines (CPGs) are adopted by the MCOs to assist practitioners and members in making decisions about appropriate health care. Each of the plans includes network providers in processes for selecting, adopting, and ongoing review of the PHGs and CPGs. WellCare's website included retired guidelines and had not been updated to reflect the guidelines that were in use at the time.

The MCOs evaluate provider compliance to the medical record documentation standards through routine annual medical record audits. Minor issues were found during review of the plans' documentation regarding medical record compliance. Recommendations were given to address the identified issues.

All the MCOs monitor continuity and coordination of care between the PCPs and other providers, primarily through medical record review but also through analysis of member complaint, grievance, appeal, and PCP change requests; member and provider surveys; review of quality-of-care concerns; etc. The plans analyze findings and use the information to address barriers and develop interventions to improve coordination of care.

Member Services

42 CFR § 438.206(c), 457.1230(a) 42 CFR § 438. 228, 42 CFR § 438, Subpart F, 42 CFR § 457. 1260

Each health plan has policies and other documents that define and describe Member Services requirements. Member Handbooks, educational materials, newsletters, and health plan websites are primary modes of communicating information about member benefits, services, rights and responsibilities, health education, and grievance processes and requirements. Additionally,

members can speak with Member Services staff at the call centers and the 24-hour nurse advice lines to receive information, address concerns, or make requests.

Processes are in place to ensure new members receive educational materials within the required timeframe and to ensure established members are continually informed about the health plans' activities, available benefits and services. Health plans use Member Handbooks, plan websites, newsletters, and other member educational materials to achieve this.

The health plans conduct the Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys annually via third-party vendors. Survey response rates continue to fall below the National Committee for Quality Assurance target response rate of 40%. CCME provided recommendations to address identified issues.

All plans addressed Member Services deficiencies from the 2019 - 2020 EQR. Areas of noncompliance for the current EQR period included documentation errors in Select Health's policies indicating that new enrollees receive welcome packets within 30 days and a Member ID Card within 15 days, instead of 14 days as required by the *SCDHHS Contract*. Minor issues were noted in member education activities and grievance documentation, and CCME provided recommendations to address them.

Quality Improvement

42CFR §438.330, 42 CFR §457.1240 (b)

Medicaid Managed Care Organizations are required to have an ongoing comprehensive quality assessment and performance improvement program for the services furnished to members. The Quality Improvement (QI) section of the EQR of the health plans in SC included review of the programs' structures, work plans, program evaluations, performance measure validations, and performance improvement project validations.

The health plans' program descriptions explain each programs' structure, accountabilities, scope, goals, and needed resources. The program descriptions are reviewed and updated at least annually. Each health plan has an annual plan of QI activities in place which includes areas to be studied, follow-up of previous projects where appropriate, timeframes for implementation and completion, and the person(s) responsible for the project(s).

The plans evaluate the overall effectiveness of their QI Programs and report this evaluation to the Board of Directors and to various Quality Improvement Committees. It was noted during Molina's previous EQR that the 2018 QI Program Evaluation did not include all quality improvement activities. Molina addressed the missing activities in their Quality Improvement Plan submitted following the previous EQR. The review of Molina's 2019 QI Program Evaluation found that summaries and analyses of all activities were included.

Performance Measure Validation

Health plans are required to report plan performance using HEDIS® measures applicable to the Medicaid population. To evaluate the accuracy of the performance measures (PMs) reported, CCME uses the CMS Protocol, *Validation of Performance Measures*. All plans use a HEDIS® certified vendor or software to collect and calculate the measures, and all were found to be "Fully Compliant." Plan rates for the most recent review year and the statewide average are reported in *Table 26, HEDIS® Performance Measure Data for HEDIS 2020* in the Quality Improvement section of this report.

The comparison of rates from 2019 to 2020 highlighted in green showed a substantial improvement of more than 10 percent year over year. The rates highlighted in red indicate a substantial decrease of more than 10 percent. *Table 1* highlights the HEDIS measures with substantial increases or decreases in rate from last year to the current year.

Table 1: HEDIS Measures with Substantial Changes in Rates

Measure/Data Element	ATC	Healthy Blue	Molina	Select Health	WellCare	Statewide Average
Effectiveness of Care: Prevention and Screening						
Adult BMI Assessment (aba)	87.35%	87.35%	93.08%	87.76%	77.91%	86.69%
Effectiveness of Care: Respiratory Conditions						
Medication Management for People With Asthma (mma)						
19-50 Years - Medication Compliance 50%	60.50%	58.38%	63.13%	58.26%	45.54%	57.16%
Asthma Medication Ratio (amr)						
12-18 Years	71.72%	72.65%	69.80%	64.19%	56.93%	67.06%
19-50 Years	60.16%	49.21%	53.33%	56.11%	39.73%	51.71%
51-64 Years	61.84%	55.22%	47.87%	47.15%	38.78%	50.17%
Total	72.68%	70.40%	68.94%	67.28%	59.49%	67.76%
Effectiveness of Care: Cardiovascular Conditions						
Persistence of Beta-Blocker Treatment After a Heart Attack (pbh)	79.37%	NA*	64.29%	77.66%	73.68%*	73.77%
Statin Therapy for Patients With Cardiovascular Disease (spc)						
Statin Adherence 80% - 40-75 years (Female)	63.97%	55.56%	48.59%	54.49%	44.55%	53.43%
Statin Adherence 80% - Total	61.58%	59.32%	47.90%	57.55%	48.37%	54.94%
Effectiveness of Care: Diabetes						
Blood Pressure Control (<140/90 mm Hg)	55.66%	56.69%	55.46%	60.29%	55.38%	56.70%
Statin Therapy for Patients With Diabetes (spd)						
Statin Adherence 80%	60.30%	52.38%	47.06%	53.12%	47.14%	52.00%

Measure/Data Element	ATC	Healthy Blue	Molina	Select Health	WellCare	Statewide Average
Effectiveness of Care: Behavioral Health						
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence (fua)						
30-Day Follow-Up: Total	11.81%	39.32%	14.61%	15.86%	17.08%	19.74%
7-Day Follow-Up: Total	7.09%	31.07%	10.05%	11.05%	12.73%	14.40%
Diabetes Monitoring for People With Diabetes and Schizophrenia (smd)	72.88%	65.36%	72.09%	71.11%	64.86%	69.26%
Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia (smc)	75.00%	NA*	NA*	83.33%*	88.89%*	75.00%
Effectiveness of Care: Overuse/Appropriateness						
Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis (aab)						
Total	49.22%	49.28%	45.49%	45.81%	46.01%	47.16%
Access/Availability of Care						
Initiation and Engagement of AOD Dependence Treatment (iet)						
*Alcohol abuse or dependence: Initiation of AOD Treatment: 13-17 Years**	NA	NA*	NA*	25.53%	36.84%	31.19%
*Alcohol abuse or dependence: Engagement of AOD Treatment: 13-17 Years**	NA	NA*	NA*	5.32%	21.05%	13.19%
Opioid abuse or dependence: Initiation of AOD Treatment: Total	43.95%	52.24%	57.44%	54.01%	44.52%	50.43%
Prenatal and Postpartum Care (ppc)						
Timeliness of Prenatal Care	93.67%	90.98%	99.76%	88.19%	93.19%	93.16%
Postpartum Care	78.83%	70.22%	83.21%	70.83%	74.94%	75.61%
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (app)						
12-17 Years	61.00%	60.00%	69.49%	64.94%	31.19%	57.32%
Total	58.71%	56.20%	66.87%	65.19%	36.36%	56.67%

NA= Data not available * indicates small denominator for rate calculation

SCDHHS Withhold Measures

The plans were required to report 12 quality clinical withhold measures. Per the *SCDHHS Medicaid Playbook* and *Policy and Procedure Guide for Managed Care Organizations*, individual measures within the quality index are weighted differently. A point value is assigned for each measure based on percentile (<10 Percentile = 1 point; 10-24% = 2 points; 25-49% = 3 points; 50-74% = 4 points; 75-90% = 5 points; >90% = 6 points). Points attained for each measure are multiplied by individual measure weights, then summed to obtain the quality index score. Health plans also reported six Behavioral Health measures as information only. *Table 2: SCDHHS*

Withhold Measures lists the specific measures reported. The 2019 rate, percentile, point value, and index score are included in the Quality Improvement section of this report.

Table 2: SCDHHS Withhold Measures

SCDHHS Withhold Measure
DIABETES
Hemoglobin A1c (HbA1c) Testing
HbA1c Control (< =9)
Eye Exam (Retinal) Performed
Medical Attention for Nephropathy
WOMEN'S HEALTH
Timeliness of Prenatal Care
Breast Cancer Screen
Cervical Cancer Screen
Chlamydia Screen in Women (Total)
PEDIATRIC PREVENTIVE CARE
6+ Well-Child Visits in First 15 months of Life
Well Child Visits in 3rd,4th,5th & 6th Years of Life
Adolescent Well-Care Visits
Weight Assessment/Adolescents: BMI % Total
BEHAVIORAL HEALTH
Follow-Up After Hospitalization for Mental Illness - 7 Days
Initiation & Engagement of Alcohol & Other Drug Dependence Treatment - Initiation – Total
Follow Up for Children Prescribed ADHD Medication – Initiation
Continuation Phase-Antidepressant Medication Management - 180 Days (6 Months)
Metabolic Monitoring for Children & Adolescents on Antipsychotics - Total
Use of First-Line Psychosocial Care for Children & Adolescents on Antipsychotics - Total

Performance Improvement Project Validation

The validation of the Performance Improvement Projects (PIPs) was conducted in accordance with the protocol developed by CMS titled, *EQR Protocol 1: Validation of Performance Improvement Projects, October 2019*. The protocol validates components of the project and its documentation to provide an assessment of the overall study design and methodology of the project.

Each health plan is required to submit performance improvement projects to CCME for review annually. CCME validates and scores the submitted projects using the CMS designed protocol to evaluate the validity and confidence in the results of each project. Twelve projects were validated for the five health plans. Results of the validation and project status for each project

are displayed in *Table 3: Results of the Validation of PIPs*. Interventions for each project are included in the Quality Improvement Section of this report.

Table 3: Results of the Validation of PIPs

Project	Validation Score	Project Status
ATC		
Postpartum Care	100/100=100% High Confidence in Reported Results	The Postpartum Care PIP did show an improvement in the rate although it was still below the benchmark rate.
Provider Satisfaction	Not validated due to a delay in conducting the Provider Satisfaction survey	CCME was unable to assess the effectiveness of those interventions because the Provider Satisfaction survey was delayed and the results were not available for this review. Staff did indicate that preliminary results showed some improvements.
Hospital Readmissions	72/72=100% High Confidence in Reported Results	The Readmissions PIP had baseline data only and therefore improvement could not be evaluated. There are several interventions underway for this PIP using ATC's Post Hospital Outreach Team to assess the member's needs before and after discharge, medication reconciliation with the primary care provider, and referrals to Case Management as needed.
Healthy Blue		
Access and Availability to Care	100/100= 100% High Confidence in Reported Results	The PIP document showed improvement in the adult access to preventive (AAP) services measure although it is still below baseline and the CAHPS indicator improved slightly from the previous remeasurement to 85.32% which is above the 81.97% goal.
Comprehensive Diabetes Care	100/100=100% High Confidence in Reported Results	The Comprehensive Diabetes Care PIP showed improvement for the Hemoglobin A1c indicator from 85.16% to 85.86% and eye exam indicator from 36.74% to 41.12% although neither measure has achieved the goal rate.
Molina		
Breast Cancer Screening	73/74=99% High Confidence in Reported Results	The screening rate decreased in the most recent remeasurement from 58.83% to 57.26%. This PIP has been ongoing for several years and has shown little or no improvements on the breast cancer rates even with all the incentives and initiatives.

Project	Validation Score	Project Status
Well-Care Program	80/80=100% High Confidence in Reported Results	Most of the measures improved, except for the Adults Access to Preventive/Ambulatory Health Services measure.
Correlation Between Member Assignment and Engagement	63/74=85% Confidence in Reported Results	This PIP had baseline and one remeasurement displayed in the report. Indicator one remained the same at 32%. Indicator two declined from 72% to 66%, and the goal is to increase that rate. Indicator three decreased from 85% to 47% and this is improvement, as the goal is to decrease indicator three.
Select Health		
Diabetes Outcomes Measures	84/85=99% High Confidence in Reported Results	The Diabetes Outcomes PIP showed a decline in the indicator rates from last year to this year. The report noted COVID as a barrier to obtaining the records, which impacted the rates.
Well Care Visits for Foster Care Population	83/83=100% High Confidence in Reported Results	The Well Child Visits PIP reported the baseline year as 2020 and other year's rates were included to gather trends for the HEDIS based measures.
WellCare		
Improving Dilated Retinal Exam (DRE) Screening	73/73=100% High Confidence in Reported Results	The rate for the Improving DRE Screening PIP was noted as unchanged from CY2018 to CY2019. According to WellCare, the project uses administrative rates, and the 2018 rate was reported for 2019 as allowed by NCQA.
Access to Care	80/80= 100% High Confidence in Reported Results	The rate for the Access to Care PIP showed a slight increase. Member incentives and outreach and provider education continue to have a slight impact on improving primary care visits.

Utilization Management

42 CFR § 438.210(a-e),42 CFR § 440.230, 42 CFR § 438.114, 42 CFR § 457.1230 (d), 42 CFR § 457. 1228, 42 CFR § 438.228, 42 CFR § 438, Subpart F, 42 CFR § 457. 1260, 42 CFR § 208, 42 CFR § 457.1230 (c),42 CFR § 208, 42 CFR § 457.1230 (c)

CCME's assessment of Utilization Management (UM) included reviews of program descriptions, program evaluations, policies, committee minutes, corresponding reports, and websites. CCME also reviewed approval, denial, appeal, and case management files. The health plans have individual UM program descriptions, policies, and procedures that define how UM and case management services are operationalized. CCME noted plans have program descriptions for specific UM services, such as case management, behavioral health (BH), and population health

management. The purpose, goals, objectives, and staff roles for physical, pharmaceutical, and behavioral health are clearly described. Medical Directors provide oversight of UM activities.

Appropriately licensed reviewers conduct medical necessity reviews of service authorization requests using Milliman Care Guidelines (MCG), InterQual Criteria, and other established criteria. Review of UM approval and denial files revealed staff regularly follow established processes, apply appropriate medical necessity criteria, and request relevant clinical information when necessary.

Health plans have established policies defining processes for handling appeals of adverse benefit determinations. Review of information related to appeals processes and requirements revealed issues with documentation such as incorrect definitions of appeal terminology, errors in forms and letter templates, and incorrect resolution timeframes.

The Case Management (CM) Program Descriptions and policies appropriately document care management processes and services provided. The health plans have well-developed Case Management programs. Each MCO has established a Population Health Management approach toward reducing health disparities, addressing social determinants of health, and enhancing the overall CM program. CCME's case management file review indicates that all plans consistently follow processes and conduct CM functions according to *SCDHHS Contract* requirements.

UM deficiencies identified during the 2019 - 2020 EQR period were adequately addressed and are described in tables in the respective UM sections. Deficiencies and minor issues identified during this current EQR are related to documentation errors, discrepancies, and omissions in policies, program descriptions or on websites related to pharmacy services, appeals, case management, and over and under-utilization monitoring.

Each health plan evaluates the UM program at least annually to assess its strengths, effectiveness, and to identify opportunities for improvement. Additionally, plans have processes to measure member satisfaction with CM services and to monitor and analyze utilization data to identify trends or issues. Evaluation results are reported to appropriate quality and UM committees.

Delegation

42 CFR § 438.230 and 42 CFR § 457.1233(b)

The health plans have established policies and procedures that document requirements for delegation of health plan functions and processes for oversight of delegated entities. Written delegation agreements are implemented for each approved delegate. The agreements include general delegation terms and conditions, processes for ongoing monitoring, sub-delegation, reporting requirements, performance expectations, and actions that may be taken for unsatisfactory performance.

Documentation of delegate oversight activities conducted by the MCOs revealed no issues for ATC and Molina. Issues identified for the remaining plans included lack of evidence that delegates are monitored for all requirements such as queries and collection of nurse practitioner collaborative agreements. WellCare did not submit evidence that annual monitoring of credentialing delegated included a file review. Despite the QIP activities undertaken to address the previous review findings, Healthy Blue had one repeat deficiency identified on the most recent review.

State Mandated Services

42 CFR § Part 441, Subpart B

Individual health plan documents and file review findings indicate all core benefits specified by the *SCDHHS Contract* are provided to eligible members. The plans follow the American Academy of Pediatrics periodicity schedule for required screenings and services and ensure EPSDT and immunization services are provided to members from birth through the month of their 21st birthday. The plans have several processes and provider engagement activities in place to educate, notify, and remind providers of needed EPSDT services. Additionally, provider compliance is monitored through member medical record documentation reviews as well as HEDIS® reports of well-child visits and claims analysis.

During the 2019 - 2020 EQRs, each plan submitted a quality improvement plan to address deficiencies identified; however, the current EQR period of 2020 - 2021 revealed that ATC, Healthy Blue, and Select Health had uncorrected deficiencies.

SC Solutions

SCDHHS contracts with South Carolina Solutions (Solutions) to provide Primary Care Case Management (PCCM) and care coordination for the Medically Complex Children's Waiver (MCCW) Program. CCME's review focused on administrative functions, committee minutes, member and provider demographics, member and provider educational materials, and the Quality Improvement (QI) and Care Coordination/Case Management Programs. The following is a summary of the review results for Solutions.

Administration: Solutions' general approach to the maintenance of written policies and procedures is evident and outlined in various policies and documents such as the Policy and Procedure Flow Diagram. Staff are educated on company policies upon hire and attest for updates and changes as applicable. The organizational structure and lines of communication are clearly defined in the organizational chart and are outlined in detail in company manuals, handbooks, and program descriptions. Personnel files were randomly selected for review, and no issues were identified.

Solutions is governed by the Board of Directors, which oversees the organization and is responsible for adopting rules, policies and procedures, and other directives for the orderly

operation of the organization, and directing company activities to maintain compliance with state, federal, and other regulatory requirements. Activities and responsibilities as outlined in the *SCDHHS Contract* are carried out and documented clearly and were found in various documents that include the Provider Manual, Employee Handbook, training materials for members and staff, and the company website.

SC Solutions has policies and procedures to address data, system, and information security and access management. The documentation indicates the organization's physical security procedures adhere to industry best practices. Solutions has an extensive Continuity of Operations plan and based on the version history, the plan is regularly reviewed and updated. The organization recently successfully tested the recoverability of its operations while conducting a migration to Google cloud services. Regular policy and procedure reviews and updates were evident. The principal of least privilege is a core aspect of the organization's access control.

Solutions' Code of Ethical Conduct defines business ethics, workplace conduct, and compliance for all employees. The role and responsibility of the Compliance Officer, Compliance Committee, and reporting options for reporting actual or suspected instances of fraud, waste, and abuse are indicated throughout employee training materials and the Compliance Plan.

Provider Services: Solutions has established processes for conducting initial provider orientation and training within 30 days of contracting and updating providers at least annually about any changes to the program. The Provider Manual is a resource for program information and includes an overview of Solutions, the Medically Complex Children's Waiver, and Enhanced Primary Care Case Management. It also includes contact information, medical recordkeeping requirements and retention timeframes, and information about language interpretation services for verbal and written communications. Solutions' website did not have the current Provider Manual posted—the version on the website was dated 2019.

During the onsite, Solutions discussed plans to revise provider contracts to incorporate new requirements related to reporting of encounter data, etc. and stated provider representatives will be hired to conduct provider training. The Provider Manual is also being revised to capture new information that providers will need to understand new requirements and to provide services to the MCCW client population.

Quality Improvement: Solutions provided the 2021 Strategic Quality Plan. This plan serves as the QI program description and describes the program's structure, accountabilities, scope, goals, and available resources. The QI program description is reviewed and updated at least annually and approved by the Compliance and Quality Management Committee.

Solutions has two projects underway, including the SCS Onsite Quality Program Coordination Implementation project. The focus of this project is to implement a new quality management program to support early risk identification of compliance deficiencies and solidify a

comprehensive retraining program. The Enhanced Provider Network Programs Modifications project is aimed at implementing a new medical informatics program to confirm provider contract compliance and identify opportunities to improve access to care.

Solutions' QI work plan identifies activities related to program priorities for addressing and improving the quality and safety of clinical care and services. During the previous EQR, CCME recommended Solutions correct the estimated completion dates and include the quarterly updates. The review of the 2021 work plan found the quarterly updates were added. However, the estimated completion dates for the Revision of Program Materials and the policy and procedure review activities were not updated. The quarterly updates for these activities indicated these activities were either delayed or an ongoing activity.

Care Coordination/Case Management: CCME's assessment of Care Coordination/Case Management includes a review of the Medically Complex Children Waiver Program Description, policies, the Provider Manual, case management files, and Solutions' website. The Waiver Program Description is very brief and gives an overview of Solution's Enhanced Primary Care Case Management program. Solutions has policies that describe and outline the methods used to provide Care Coordination and case management services such as Policy CHS.CM.MCCW.01.02, Medically Complex Criteria-Medical Eligibility Assessment, and Policy CHS.CM.MCCW.01.08, Care Planning/Monthly Summary Report. However, documentation of processes used to develop, monitor, evaluate. and coordinate the Person-Centered Service Plan (PCSP) was not identified.

Humana Healthy Horizons

CCME conducted a readiness review for Humana Healthy Horizons (Humana), a new MCO providing services for the Healthy Connections population in SC. This review was to assess the preparedness of Humana to enroll Medicaid beneficiaries as members in their MCO and to provide the necessary and contractually required health care services to those members. A summary of the readiness review results follows. Details regarding this review can be found in the narrative section of this report.

Administration: The review of the Administration section covered the areas of policy development and management, staffing levels, compliance, information systems, and confidentiality. Many of the policies received in the desk materials contained wording directly from the *SCDHHS Contract* and did not specifically indicate Humana's process for meeting the requirements. Many of the policies contained information related to Medicare or to other lines of business and were not specific to South Carolina. The procedure section of each policy should be reviewed to 1) expand internal procedures or protocols, 2) outline steps currently in place but not documented within existing policies, and 3) indicate steps that need to be taken internally to accomplish the intent of the contract language as applicable.

It was reported during onsite discussions that key contractually required positions were in recruitment with some offers of employment pending. The Utilization Review Staff, Case

Management Staff, Quality Improvement (Coordinator, Manager, Director), Quality Assessment and Performance Improvement Staff, Member Services Manager, Medical Director, and Board-Certified Psychiatrist/Psychologist positions are either currently vacant or do not meet the South Carolina residency requirements.

The organization's Information System Capabilities Assessment (ISCA) documentation and online resources confirm that data security is a priority. The documentation demonstrates adherence to best practices for both day-to-day operations and broader scenarios such as disaster planning.

The Humana Corporate Compliance Plan emphasizes the goal of creating a workplace environment in which ethics are integral in all aspects of day-to-day operations. The Compliance Committee is chaired by the Chief Compliance Officer and includes members who have decision-making authority and responsibility throughout the organization. Oversight, monitoring, and auditing activities include internal monitoring and audits, risk-based assessments, and as appropriate, external monitoring and auditing to evaluate Humana's compliance with state and federal requirements and the overall effectiveness of the Compliance Program.

Provider Services: Humana follows National Committee for Quality Assurance (NCQA) credentialing standards. Corporate policies and health plan policy supplements document processes for credentialing and recredentialing. Humana staff verbalized that a 30 calendar-day timeframe will be followed for processing credentialing applications; however, this was not documented in policy. The process and timeframe for reporting to SCDHHS any network providers or subcontractors that has been debarred, suspended, and/or excluded from participation in Medicaid, Medicare, or any other federal program could not be identified. Humana did not have a local Credentialing Committee and there was no South Carolina representation on the Corporate Credentials Committee, which reviewed and made the final credentialing determination for the South Carolina provider network.

The review of initial credentialing files revealed various issues. These issues were related to the dates on credentialing determination letters, collection of collaborative agreements for nurse practitioners, CLIA verification, organizational provider attestations, and verification of liability coverage for organizational providers.

Humana appropriately documented provider access requirements and processes for monitoring network adequacy. The process for ensuring members have a choice of at least two contracted specialists accepting new patients within their geographic area was not identified. Processes were established for initial and ongoing provider training. A link in the Provider Manual to access the Cultural Competency Plan on Humana's website did not take the user to the Cultural Competency Plan, and the plan could not be located elsewhere on the website.

Processes were in place for review and adoption of preventive health guidelines and clinical practice guidelines. Humana posts the guidelines on its website and information about the

guidelines is included in the Provider Manual. The Readiness Review revealed the guidelines did not include the American Academy of Pediatrics (AAP)/Bright Futures guidelines or any guidelines for Well Child Care other than a few specific screenings for children from the Prevention TaskForce.

CCME could not identify in a policy or other document Humana's process for evaluating coordination of care between providers. Discussion during the onsite revealed a process had not been established.

Member Services: CCME's review of Member Services focused on areas such as member rights and responsibilities, member education and informational materials, Member Satisfaction Surveys, and grievance procedures. Humana has policies and procedures that define and describe Member Services activities and provide guidance to staff for performing those activities.

Members will receive a Welcome Kit with instructions and information to begin utilizing services and benefits. The Provider Manual and Member Handbook will be accessible on the website when it is launched. CCME noted that the Member Handbook has limited and inconsistent information about copayment, minimal information on EPSDT services, and does not include Humana's process for notifying members of changes in benefits or services. Additionally, several documentation issues related to filing and handling grievances were noted.

Quality Improvement: Humana provided the Healthy Horizons in South Carolina Quality Assessment and Performance Improvement Program Description, 2021, a copy of the Quality Improvement (QI) work plan template, and several QI policies. The program description provided the goals and objectives for the QI program; however, it did not address the scope of the program or include details regarding the utilization data Humana plans to monitor. The Quality Assurance Committee (QAC) is the local committee responsible for the development and implementation of Humana's QI program in South Carolina. Voting members include Humana's executives, medical and quality directors, and other managers. Medical and behavioral health network providers will be included as non-voting members. It is recommended Humana consider including the network providers as voting members of the QAC.

Humana will contract with an NCQA-licensed organization to conduct HEDIS audits. Policy (Performance Measures)-005 (HUM-SC-QM-005-01) provides the process for collecting and reporting performance data. This policy incorrectly contains references to Medicare requirements. The materials submitted lacked details regarding how the performance improvement projects will be handled. The QI Program Description and policies fail to include the details of how the project topics are developed or selected, what potential data will be used, and the steps needed for approval of the project. Humana provided the Performance Improvement Project template as an example of how performance improvement projects will be documented. This template meets the requirements. However, the template should also include

statistical evidence if sampling is used for a project and the barriers and interventions documented on a separate page.

Utilization Management: The Utilization Management (UM) Program Description outlines the purpose, goals, objectives, and staff roles for physical health and behavioral health. Humana has several policies and documents that describe and define UM service areas.

The position of Transition Coordinator, required by the *SCDHHS Contract, Section 5.6.2*, has not been designated. Humana staff reported recruitment efforts are in progress.

Appropriate reviewers will conduct service authorization requests using guidelines from Milliman Clinical Guidelines (MCG), SC Medicaid manuals, behavioral health guidelines from the American Society of Addiction Medicine (ASAM), and other established criteria. Humana has established policies defining processes for handling appeals of adverse benefit determinations. Several documentation issues were noted related to definitions, processes, and timeframes for member appeals.

The Care Management Program Description-004A and policies document care management processes and services provided. However, the requirements for Targeted Care Management services could not be identified.

A Fraud, Research, Analytics and Concepts (FRAC) document, UM Data Plan, and UM Program Description were submitted to review Humana's approach for evaluating over- and under-utilization. However, these documents did not include a defined timeline for utilization data analysis, specific areas of interest (readmissions, ER rates, pharmacy, etc.), who will set target rates, who will assist with monitoring and interventions, and plans to mitigate identified issues.

Delegation: Humana retains accountability for each delegated service and monitors the performance of delegated entities. A pre-delegation review is conducted to assess each entity's program, associated policies and procedures, staffing capabilities, and performance record prior to the entity performing the delegated activity. Humana will conduct annual oversight monitoring for each delegated entity to determine whether the delegated activities are being carried out as required.

The Delegation Policy attached to Policy (Delegation)-001 defines processes for delegation approval and states the Delegated Services Addendum and Delegation Attachment must be executed for each delegated function; must describe the activities and the responsibilities of Humana and the delegate; must require reporting at least semiannually; must describe how Humana evaluates delegated performance; and must describe the remedies available if the delegate does not fulfill its obligations. However, the policy does not fully address requirements for sub-delegation. It fails to include that SCDHHS must receive prior notification of any further delegation by a subcontractor. Also, the policy addresses checking the Office of Inspector General's List of Excluded Individuals/Entities and System for Award Management during the pre-

delegation assessment but does not address the queries on an ongoing basis as required by the *SCDHHS Contract, Section 2.5.13*.

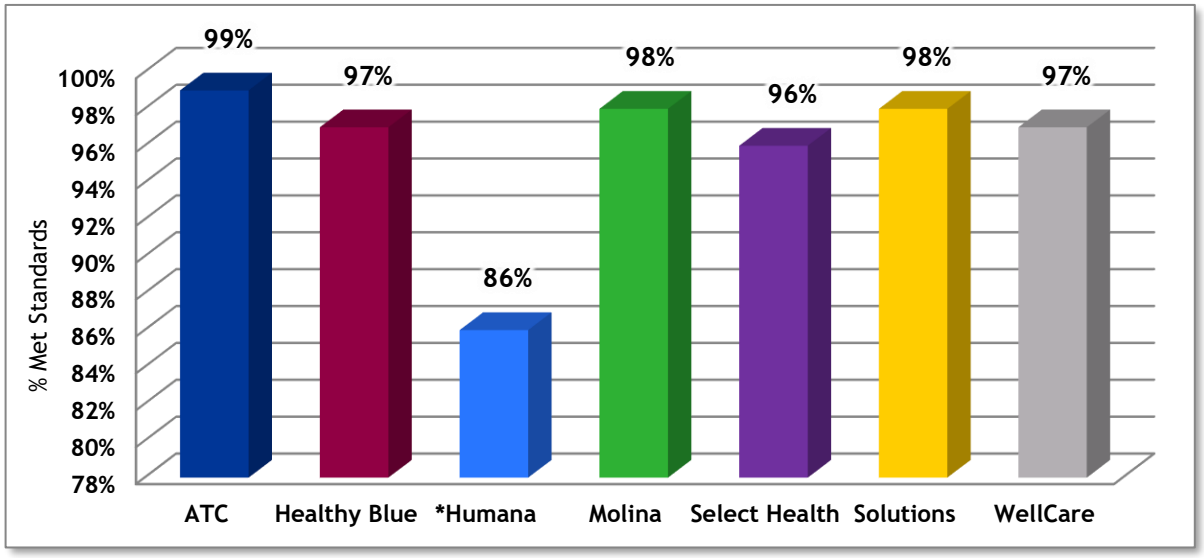
Quality Improvement Plans and Recommendations from Previous EQR

For a health plan not meeting requirements, CCME requires the plan to submit a Quality Improvement Plan (QIP) for each standard identified as not fully met. CCME provides technical assistance to each health plan until all deficiencies are corrected. During the current EQR, CCME assessed the degree to which the health plan implemented the actions to address deficiencies identified during the previous EQR. ATC, Healthy Blue, and Select Health had deficiencies from the 2019 - 2020 EQR for which the QIP was not implemented. These were related to provider network adequacy monitoring (ATC and Select Health) and oversight of credentialing delegates (Healthy Blue).

Scoring Results

The following figure illustrates the percentage of "Met" standards achieved by each health plan during the 2020 – 2021 EQRs. The score noted for Humana represents the Readiness Review score.

Figure 1: Percentage of Met Standards



Scores were rounded to the nearest whole number

The following table provides an overview of the scoring for each section of the EQR.

Table 4: Overall Scoring

	Met	Partially Met	Not Met	Not Evaluated	Total Standards	*Percentage Met Scores
Administration						
ATC	40	0	0	0	40	100%
Healthy Blue	40	0	0	0	40	100%
Humana	32	1	7	0	40	80%
Molina	40	0	0	0	40	100%
Select Health	40	0	0	0	40	100%
Solutions	34	0	0	0	0	100%
WellCare	40	0	0	0	40	100%
Provider Services						
ATC	75	1	0	0	76	99%
Healthy Blue	73	2	1	0	76	96%
Humana	68	5	2	0	75	91%
Molina	73	2	1	0	76	96%
Select Health	72	1	3	0	76	95%
Solutions	5	0	0	0	5	100%
WellCare	72	3	1	0	76	95%
Member Services						
ATC	33	0	0	0	33	100%
Healthy Blue	33	0	0	0	33	100%
Humana	29	3	0	0	32	91%
Molina	33	0	0	0	33	100%
Select Health	32	1	0	0	33	97%
Solutions	NA	NA	NA	NA	NA	NA
WellCare	33	0	0	0	33	100%
Quality Improvement						
ATC	14	0	0	0	14	100%
Healthy Blue	14	0	0	0	14	100%
Humana	10	3	0	0	13	77%
Molina	13	1	0	0	14	93%
Select Health	14	0	0	0	14	100%
Solutions	7	0	0	0	7	100%
WellCare	14	0	0	0	14	100%
Utilization						

	Met	Partially Met	Not Met	Not Evaluated	Total Standards	*Percentage Met Scores
ATC	45	0	0	0	45	100%
Healthy Blue	44	1	0	0	44	100%
Humana	36	6	0	0	42	86%
Molina	45	0	0	0	45	100%
Select Health	44	1	0	0	45	98%
Solutions	14	1	0	0	15	93%
WellCare	44	1	0	0	45	98%
Delegation						
ATC	2	0	0	0	2	100%
Healthy Blue	1	1	0	0	2	50%
Humana	1	1	0	0	2	50%
Molina	2	0	0	0	2	100%
Select Health	1	1	0	0	2	50%
Solutions	NA	NA	NA	NA	NA	NA
WellCare	1	1	0	0	2	50%
State Mandated Services						
ATC	3	0	1	0	4	75%
Healthy Blue	3	0	1	0	4	75%
Humana	NA	NA	NA	NA	NA	NA
Molina	4	0	0	0	4	100%
Select Health	3	0	1	0	4	75%
Solutions	NA	NA	NA	NA	NA	NA
WellCare	4	0	0	0	4	100%
Totals						
ATC	212	1	1	0	214	99%
Healthy Blue	207	4	2	0	213	97%
Humana	176	19	9	0	204	86%
Molina	210	3	1	0	214	98%
Select Health	206	4	4	0	214	96%
Solutions	60	1	0	0	61	98%
WellCare	208	5	1	0	214	97%

**Percentage is calculated as: (Total Number of Met Standards / Total Number of Evaluated Standards) × 100*

Coordinated and Integrated Care Organizations Annual Review

CCME conducted an External Quality Review of the Coordinated and Integrated Care Organizations (CICOs) that participate in the Healthy Connections Prime program and provide services for the dual eligible Medicare/Medicaid population (MMP). Those plans include ATC, Molina, and Select Health. This review focused on network adequacy for home and community-based service and behavioral health providers, over- and under-utilization, and care transitions.

CCME requested a complete list of all contracted HCBS providers currently in each health plan's network. ATC reported membership in 37 counties. Of the 259 services across 37 counties, there were 259 (100%) that met the minimum requirements. For Molina, 45 counties were documented as having enrollment in the MMP Member Demographics 2020 file. Of the 315 services across 45 counties, 315 met the minimum requirements, resulting in a validation score of 100%. This was a 1% improvement from last year's rate of 99%. Select Health's network had 46 counties documented as having members. Of the 322 services across 46 counties, 322 met the minimum requirements resulting in a validation score of 100%, which is sustained from last year's rate of 100%.

The CICOs are also required to have a network of behavioral health providers to ensure a choice of at least two providers located within no more than 50 miles from any enrollee unless the plan has a SCDHHS-approved alternative standard. All three plans meet these requirements.

Evaluation of Over/Under Utilization

The CICOs are required to monitor and analyze utilization data to look for trends or issues that may provide opportunities for quality improvement. The over- and under-utilization focuses on five key indicators: 30-day hospital readmission rates for any potentially avoidable hospitalization, length of stay for hospitalizations, length of stay in nursing homes, emergency room utilization, and the number and percentage of enrollees receiving mental health services. All CICOs met the requirements for evaluating over- and under-utilization.

Care Transitions

All the CICOs had established policies for conducting transition of care functions. In the file review for ATC, CCME noted an overall improvement in notifications of admissions and discharges between Utilization Management and Care Management staff and between ATC and the healthcare facilities. There were some areas identified as needing improvement. These were related to completing reassessments after a change in the member's status, conducting clinical follow-up within 72 hours of the member's transition, conducting outreach to the member's primary care physician, collaborating with facility discharge planners, and medication monitoring and adherence.

Molina implemented an improvement strategy and added two additional staff to the transition of care (TOC) team to assist with clinical assessments and administrative tasks. Overall, files reflected staff are providing appropriate services and meeting contract requirements.

Select Health also implemented improvement strategies involving additional trainings, workgroups, and process improvement activities. The review of TOC files revealed an overall improvement; however, CCME noted a weakness in that the files did not include documentation of reassessment after a trigger event, such as a hospitalization or change in the member's status. Also, CCME could not determine if data for transitions to higher levels of care was analyzed to evaluate for contributing factors or to identify improvement opportunities.

B. Overall Recommendations

The results of 2020 - 2021 EQR activities demonstrate that the managed care organizations are well-qualified and committed to facilitating timely, accessible, and high-quality healthcare for SC members.

SCDHHS' requirement that MCOs must achieve NCQA accreditation, as well as its stipulations regarding the number of performance improvement projects that plans must conduct, indicate that the State is committed to a higher level of quality monitoring and accountability for its health plans. CCME recommends that SCDHHS continue to use measures from the annual network adequacy reviews, HEDIS audits, and performance improvement project validation as the primary means for assessing the Quality Strategy's success as applied to the integrated physical and behavioral health services delivered by its health plans. The 2020 - 2021 EQR assessment results, including the identification of health plan strengths, weaknesses, and recommendations, attest to the positive impact of SCDHHS' strategy in monitoring plan compliance, improving quality of care, and aligning healthcare goals with priority topics. The Quality Strategy outlined several SCDHHS initiatives that align with CMS priority areas. Based on the initiatives in the Quality Strategy, CCME developed recommendations to allow MCOs to fulfill the goals of the Quality Strategy.

Table 5: SCDHHS Quality Initiatives displays the recommendations for each initiative.

Table 5: SCDHHS Quality Initiatives

SCDHSS Quality Initiative	Recommendation
NCQA Accreditation	Maintain initiative as planned.
Quality Index Withhold Program	Continue to monitor indices for Diabetes, Women's Preventive Health, and Children's Preventive Health; determine timeline for inclusion of Behavioral health index as part of the index withhold program.

SCDHSS Quality Initiative	Recommendation
Patient-Centered Medical Home (PCMH) Incentive Program	Continue educational support to practices pursuing PCMH recognition to demonstrate the evidence supporting the ability of PCMHs' in reducing hospital and emergency department visits, mitigating health disparities, and improving patient outcomes.
Payment Reform (APM Goals)	Continue to evaluate the APM percentage goal and determine if revisions to LAN categories should be established
Auto-Assignment	Continue the rotating assignment structure based on HEDIS and CAHPS scores for members who do not choose to select a managed care plan.
Quality Through Technology and Innovation in Pediatrics (QTIP) Program	Determine if the 3- to 6-year-old age group will continue to be the focus for QTIP program; continue to monitor interest of pediatric groups.
Birth Outcomes Initiative	Determine if Safe Sleep initiative will continue to be monitored as a priority topic; consider focusing on interventions to improve supplemental outcomes, such as delivery site access and birthweight data.

The following tables provide an overview of strengths, weaknesses, and recommendations related to quality, timeliness, and access to care identified after the annual reviews of the Managed Care Organizations, Coordinated and Integrated Care Organizations, Solutions' primary care case management program, and the readiness review for Humana.

Table 6: Evaluation of Quality, Timeliness, and Access to Care for MCOs

	Strengths	Weaknesses	Recommendations
Quality	• Health plans regularly review and revise policies and procedures to meet state and federal guidelines • Staffing requirements are clearly denoted on each plan's organizational chart. • Guidelines for recognizing and reporting compliance and FWA issues are in place. • MCO policies appropriately document processes and requirements for provider credentialing and recredentialing. • Overall, appropriate processes are in place for initial and ongoing provider education, with adjustments made to ensure provider education processes	• For three health plans, issues were identified with Credentialing Committee membership, meeting frequency, and/or established quorums.	• The plans should ensure Credentialing Committees include appropriate network provider representation, and clearly and correctly document committee meeting frequently and quorums.
		• Credentialing files for two plans were not compliant with credentialing elements, such as required queries and primary source verifications.	• Ensure all credentialing and recredentialing requirements are met.
		• Two plans had inconsistencies in copayment information in Member Handbooks and did not document services	• Ensure Member Handbooks include correct copayment amounts and information about services that do not require referrals.

	Strengths	Weaknesses	Recommendations
	continue while under restrictions related to the COVID-19 pandemic. • Processes are in place for selection, adoption, and ongoing review of Preventive Health and Clinical Practice Guidelines, including obtaining network provider input. • Continuity of care between PCPs and other providers is assessed through medical record review and other avenues. Findings are analyzed and used for quality improvement activities. • All health plans have appropriate policies in place outlining provider medical record documentation standards and for assessing provider compliance with those documentation standards. • The health plans have QI program descriptions that described the programs' structure, accountabilities, scope, goals, and needed resources. The program descriptions are reviewed and updated at least annually. • All the MCOs have performance improvement projects underway aimed at improving the care their members receive. Topics included postpartum care, diabetes, and well-care visits. • Two MCOs have performance improvement projects that address access to care. Healthy Blue's Access and Availability to Care PIP showed improvement in the adult access to preventive (AAP) services measure although it is still below baseline and the CAHPS indicator improved slightly. • Interventions for PIPs were planned and implemented for members, providers, and system-based components. Barrier analyses were detailed and thoughtful.	that do not require a PCP referral. • Member satisfaction survey response rates continue to fall below the National Committee for Quality Assurance target response rate of 40%. • Indicator rates declined for several PIPs suggesting interventions were not yet effective. • Two plans had documentation issues related to pharmacy information, requirements, timeframes, and procedures. • For two plans, documentation of appeals information, requirements, and procedures contained errors, discrepancies, and omissions. • Delegation oversight documentation does not reflect delegates are monitored for all credentialing elements, such as required queries and collection of nurse practitioner collaborative agreements. One plan did not conduct file review for	 • The plans should continue to work with survey vendors to identify methods that can improve Member Satisfaction Survey response rates. • Continue interventions as COVID restrictions are reduced to determine impact when restrictions are not in-place. Conduct analyses to determine if specific interventions are more effective by isolating those interventions for a period (quarterly) and computing interim rates to assess impact. Continue to monitor indices for Diabetes, Women's Preventive Health, and Children's Preventive Health; determine timeline for inclusion of behavioral health index as part of the index withhold program. • Ensure documentation of pharmacy requirements, procedures, timeframes, and definitions is correct. • Ensure documentation of appeals requirements, procedures, and definitions is complete and correct. • Ensure delegation oversight tools document oversight for all required credentialing elements and a file review is conducted during oversight of credentialing delegates.

	Strengths	Weaknesses	Recommendations
	• Determination letters are written in language that is easily understood by a layperson and medical terminology is explained, when used. • Health plans appropriately monitored and analyzed data for over and under- utilization of medical services. • The MCOs have appropriate processes in place for pre-delegation assessment and implementation of written delegation agreements for all delegated entities. • Health plans provided all core benefits required by the SCDHHS Contract.	credentialing delegate oversight.	
Timeliness	• Review of UM approval and denial files revealed staff regularly follow established processes, apply appropriate medical necessity criteria, and request relevant clinical information when necessary. • Grievance files reflect timely acknowledgement, resolution, and review by appropriate staff.		
Access to Care	• All health plans have established processes for ongoing monitoring and assessment of provider networks. • If network gaps are identified, plans begin recruiting to fill the gaps. Single case agreements are implemented as needed when a network provider is not available.	• For three plans, Geo Access reports did not include all required Status 1 provider types and/or network adequacy reports included errors in documentation of required access parameters.	• Ensure network assessments include all Status 1 provider types and that correct parameters are documented and used for time/distance measurements.
		• Provider Access and Availability Studies demonstrated a decrease in the rate of providers successfully contacted for four plans and an overall decrease in the rate of providers that reported they accepted the health plan(s).	• Examine current methods for updating provider contact information. Develop strategies to improve this process, such as developing additional methods for providers to update their contact information.
		• Provider Directories for two plans did not include all required elements.	• Review and revise Provider Directories as needed to include all required elements.

	Strengths	Weaknesses	Recommendations
		• Issues were noted in Provider Manuals related to documentation of appointment access standards for specialists, member benefits, and copayments,	• Ensure providers are aware of appointment access standards and are given correct and complete information about member benefits and copayments.

Table 7: Evaluation of Quality, Timeliness, and Access to Care for CICOs

	Strengths	Weaknesses	Recommendations
Quality	• All CICOs are monitoring the key indicators for evaluating over- and under-utilization.	• Two plans continue to have issues related to Transition of Care reassessments and follow-up after a member transition occurs.	• Ensure all required TOC functions are conducted and clearly documented in the members' files.
		• Transitions that result in a move to a higher level of care are not analyzed to determine factors that contributed to the change and actions needed to improve outcomes.	• CICOs should collect and analyze the data for transitions that result in a higher level of care to identify contributing factors and improvement opportunities.
Timeliness	• No issues were identified with timeliness.		
Access to Care	• No issues were identified with access to care. • All CICOs demonstrated adequate provider networks to meet SCDHHS' requirements for HCBS and BH providers.		

Table 8: Evaluation of Quality, Timeliness, and Access to Care for Humana

	Strengths	Weaknesses	Recommendations
Quality	• Clear and easily accessible contact information is available to report FWA. • Humana staff are provided with security information and updates in addition to required security training.	• Many policies and procedures only included SCDHHS Contract language and did not specifically indicate Humana's processes for addressing requirements.	• Complete a comprehensive review of policies and procedures and add Humana's processes to meet contractual requirements.
		• Seven key positions are currently in phases of	• Finalize the recruitment process to secure the

	Strengths	Weaknesses	Recommendations
	• The Corporate Bold Gold Initiative focuses on the impact of food insecurity and social isolation and captures the impact on healthy days in communities. • The Cultural Competency Training 2021 document on Humana's website includes information about culture and cultural competence, clear communication, various subcultures and populations, and strategies for working with seniors and people with disabilities. • Member materials and information can be accessed from the website and the online member portal, and delivered via email, social media platforms, and free text messages. • Humana's sample of the 2021 Quality Assessment and Performance Improvement Program work plan included all requirements and will be updated as needed. • Determination letter templates are written in language that is easily understood by a layperson. • The Member Handbook instructs that a signed Authorization of Representative form is needed for a provider or another person to act on a member's behalf.	recruitment but are not filled.	seven current vacant key positions.
		• Processes for identifying and reporting to SCDHHS any network providers or subcontractors that have been debarred, suspended, and/or excluded from participation in Medicaid, Medicare, or any other federal program immediately upon discovery were not documented.	• Revise an appropriate policy to define the process Humana will follow for reporting to SCDHHS any network providers that have been debarred, suspended, and/or excluded from participation in Medicaid, Medicare, or any other federal program immediately upon discovery.
		• Humana did not have a local Credentialing Committee, as required by the *SCDHHS Policy and Procedure Guide for Managed Care Organizations, Section 2.8.*	• Establish a local (plan level) Credentialing Committee. Ensure the MCO Medical Director oversees and has overall responsibility for committee activities and that the committee includes network provider representation from various specialties, including mid-level practitioners. A committee charter should be developed to specify the committee's roles and responsibilities, membership, meeting frequency, quorum, attendance requirements, etc.
		• Credentialing file review revealed issues related to dates on credentialing determination letters, failure to collect nurse practitioner collaborative agreements, failure to verify CLIA certificates, CLIA verifications conducted after the credentialing decision date, no evidence of attestation for most organizational providers, and failure to verify liability coverage for organizational providers.	• Ensure credentialing files contain evidence that credentialing determination letters are dated correctly and that credentialing files contain evidence of compliance with all credentialing requirements.

	Strengths	Weaknesses	Recommendations
		• The Humana Cultural Competency Plan was not available on the website.	• Ensure the Cultural Competency Plan is available on the website.
		• Humana's adopted preventive health guidelines did not include the AAP/Bright Futures guidelines or any guidelines for Well Child Care other than a few specific screenings for children.	• Ensure Humana's approved preventive health guidelines include a guideline for Well Child Care screenings according to the AAP periodicity schedule. The guideline should be included in Policy QM-001-17.
		• The process for monitoring coordination of care between providers could not be identified program descriptions or in policies. Humana could not verbalize a process for this activity.	• Document the process for monitoring coordination of care between providers in a policy, including methods of monitoring and assessment, processes for addressing any identified deficiencies, etc.
		• Policy (Member Surveys) HUM-SC-QM-007-01 does not include information for the Children with Chronic Conditions CAHPS survey.	• Edit policy (Member Survey) HUM-SC-QM-007-01 to include information for the Children with Chronic Conditions version of the CAHPS survey.
		• The QI Program Description does not address the scope of the program and does not include details regarding the data Humana plans to monitor for potential over and underutilization issues.	• Update the QI Program documents to address the scope of the program and details regarding the data used to monitor over- and under-utilization.
		• Medical and behavioral health network providers will not be included as voting members on the Quality Assurance Committee.	• Network providers invited to participate in the QI program should be included as voting members on the quality committees.
		• The materials submitted by Humana lacked details regarding how the performance improvement projects will be handled.	• Update the performance improvement project template to include evidence of the statistical testing if sampling is used, separate the interventions and barriers documentation, and include the type of intervention.
		• Policies did not include the specific process for	• Update the QI Program documents to address

	Strengths	Weaknesses	Recommendations
		monitoring South Carolina Medicaid provider performance.	details regarding monitoring provider performance.
		• The UM Program does not have oversight from a Medical Director and Behavioral Health Medical Director. Humana reported recruitment efforts are in progress.	• Continue recruitment efforts to fill the Medical Director and Behavioral Health Medical Director positions.
		• Although Humana staff indicated the Medical Management Committee (MMC) includes network providers, documentation in the UM Program Description and QI Program Description do not indicate providers from the network are members of the MMC.	• Revise the UM or QI Program Description, committee charters, etc. to indicate the network providers included as members of the MMC.
		• Humana does not have a policy defining processes and requirements for coverage of hysterectomies, sterilizations, and abortions.	• Develop and document in a policy Humana's processes for handling hysterectomies, sterilizations, and abortions.
		• The UM Program Description does not include a description of post stabilization services.	• Include a description for post stabilization services in the UM Program Description.
		• Appeal terminology is not correctly defined in the Member Handbook and outdated terminology is used in policies.	• Update documents to appropriately define appeal terminology and to use current terminology.
		• Appeal policies reference other states, incorrectly indicate services for which Humana processes appeals, and do not contain full information about appeal requirements and processes.	• Ensure appeal policies contain current, complete, and correct information for appeals processes in South Carolina.
		• Processes for ensuring Targeted Care Management services are provided were not documented.	• Define in an appropriate document, the process for ensuring Targeted Care Management services are provided as contractually required.

	Strengths	Weaknesses	Recommendations
		• A Transition Coordinator has not been designated. Humana staff explained recruitment efforts are in progress.	• Continue recruitment efforts for a Transition Coordinator.
		• The process or plan for how Humana will detect and monitor over- and under-utilization was incomplete.	• Develop a plan or process for how Humana will monitor over and underutilization.
		• Delegation policies do not address requirements for checking the Office of Inspector General's (OIG) List of Excluded Individuals and Entities (LEIE) and System for Award Management (SAM) on an ongoing basis and notifying SCDHHS prior to any further delegation by a subcontractor.	• Revise applicable Delegation policies to include all required elements for delegation of health plan services.
Timeliness		• Policy (CORE Credentialing and Recredentialing)-001 did not indicate Humana will follow a 30-day timeframe for processing credentialing applications.	• Revise Policy (CORE Credentialing and Recredentialing)-001 to indicate a 30-day timeframe will be followed for SC provider credentialing
		• Grievance acknowledgment timeframes are not included in the Grievance and Appeal policy.	• Include grievance acknowledgment timeframes in Policy (South Carolina Medicaid Grievance and Appeal Policy DRAFT)-001E.
		• The grievance filing timeframe in the South Carolina Medicaid Grievance First Level Review-001F document is incorrect.	• Correct the grievance filing timeframe in the South Carolina Medicaid Grievance First Level Review-001F document.
		• The Member Handbook and Provider Manual do not include information about extensions of service authorization timeframes.	• Include information about extensions of service authorization determination timeframes in the Member Handbook and Provider Manual.
		• Appeal policies do not include the requirement for provision of notice of appeal resolution within 30 days of receipt of the appeal and the timeframe	• Ensure appeal policies reference the correct timeframe for notification of appeal determinations and requesting State Fair Hearings.

	Strengths	Weaknesses	Recommendations
		for requesting a State Fair Hearing.	
Access to Care		• Humana's plan to ensure members have a choice of at least two contracted specialists who are accepting new patients within their geographic area was not identified.	• Revise an appropriate policy to address Humana's plan to ensure members have a choice of at least two contracted specialists accepting new patients within the members' geographic area.
		• Humana waives copayments for all members. However, the Core Benefits and Services policy indicates copayments are allowed for members aged 19 and older, and the Member Handbook mentions copayments for medications.	• Edit the Member Handbook and Policy (UM- Core Benefits and Services)-007 to contain correct information about copayments.
		• Processes for notifying members of changes in benefits or services were not identified in the Member Handbook or other documents, and the Member Handbook has very limited information on EPSDT services.	• Include Humana's process for notifying members of changes in benefits or services and comprehensive information on EPSDT services in the Member Handbook.
		• The Member Handbook listed conflicting contact information for obtaining grievance related services.	• Edit the Member Handbook to correctly document the contact information for obtaining grievance related services.
		• The Member Handbook and Provider Manual include limited information about coverage of hysterectomies, sterilizations, and abortions.	• Update the information in the Member Handbook and Provider Manual regarding coverage of hysterectomies, sterilizations, and abortions

Table 9: Evaluation of Quality, Timeliness, and Access to Care for SC Solutions

	Strengths	Weaknesses	Recommendations
Quality	• Information System backups are tested regularly to ensure and verify the integrity of the data backup. • Training materials and processes for staff are clear and consistent. • SCDHHS reported that Solutions staff monitoring for and reporting suspected FWA is invaluable in the investigation, resolution, and reduction of potential violations throughout the state. • Solutions plans to employ provider representatives to educate providers about upcoming changes in provider requirements as well as the MCCW program in general. • Quality improvement projects are initiated when opportunities to correct or improve services or processes are identified. Solutions had two projects underway.	• Discrepancies in the frequency of ride-along staff supervision were noted in policies.	• Revise applicable policies to reflect the correct frequency of ride-along supervision with each Care Coordinator.
		• An outdated version of the Solutions Provider Manual was on the website.	• Ensure the website contains current documents.
		• Documentation of process for implementing, coordinating, monitoring, evaluating, and updating PSCPs with participants, PCPs and SCDHHS is minimal and confusing.	• Clearly document Solutions' process for implementing, coordinating, monitoring, evaluating, and updating PSCPs.
		• PCP involvement in the PCSP process is not clearly described or documented.	• Edit the Provider Manual to correctly reflect the PCPs participation in PCSPs.
Timeliness	• No issues were identified related to timeliness		
Access to Care	• No issues were identified related to access to care. • Participants are given required information and forms at the time of enrollment and receive information to access local and state-wide resources.		

BACKGROUND

As detailed in the *Executive Summary*, CCME as the EQRO conducts an EQR of each MCO participating in the Medicaid Managed Care Program on behalf of SCDHHS. Federal regulations require that EQRs include three mandatory activities: validation of PIPs, validation of PMs, and an evaluation of compliance with state and federal regulations for each health plan.

Federal regulations also allow states to require optional activities that include:

- Validating encounter data
- Administering and validating consumer and provider surveys
- Calculating additional PMs
- Conducting PIPs and quality of care studies

After completing the annual review of the required EQR activities, CCME submits a detailed technical report to SCDHHS and the health plan. This report describes the data aggregation and analysis, as well as the manner in which conclusions were drawn about the quality, timeliness, and access to care furnished by the plans. The report also contains the plan's strengths and weaknesses, recommendations for improvement, and the degree to which the plans addressed quality improvement recommendations made during the prior year's review. Annually, CCME prepares a comprehensive technical report for the State which is a compilation of the individual annual review findings. The comprehensive technical report for contract year 2020 through 2021 contains data for: ATC, Healthy Blue, Molina, Select Health, Solutions, and WellCare.

The report also includes EQR findings for the readiness review for Humana and plans participating in the Healthy Connections Prime Program under review during this reporting period.

METHODOLOGY

The process used by CCME for the EQR activities is based on CMS protocols and includes a desk review of documents submitted by each health plan and onsite visits to each plan's office. After completing the annual review, CCME submits a detailed technical report to SCDHHS and the health plan (covered in the preceding section titled, *Background*). For a health plan not meeting requirements, CCME requires the plan to submit a quality improvement plan for each standard identified as not fully met. CCME provides technical assistance to each health plan until all deficiencies are corrected.

During this contract year, all onsite visits were conducted virtually due to restrictions from the COVID-19 pandemic.

The following table displays the dates of the EQRs conducted for each health plan.

Table 10: External Quality Review Dates

Health Plan	EQR Initiated	Onsite Dates	Reports Submitted
ATC ATC MMP	12/7/20	2/24/21 - 2/25/21	3/25/21
Healthy Blue	3/15/21	6/2/21 - 6/3/21	7/2/21
Humana	2/1/21	4/6/21 - 4/7/21	4/7/21
Molina Molina MMP	2/8/21	4/21/21 - 4/22/21	5/20/21
Solutions	6/7/21	7/21/21	8/19/21
Select Health	9/11/20	11/11/20 - 11/12/20	12/10/20
Select Health MMP	5/3/21	6/23/21	7/21/21
WellCare	10/19/20	12/16/20 - 12/17/20	1/14/21

FINDINGS

The plans were evaluated using the standards developed by CCME and summarized in the tables for each of the sections that follow. CCME scored each standard as fully meeting a standard ("Met"), acceptable but needing improvement ("Partially Met"), failing a standard ("Not Met"), "Not Applicable," or "Not Evaluated." The tables reflect the scores for each standard evaluated in the EQR. The arrows indicate a change in the score from the previous review. For example, an arrow pointing up (↑) would indicate the score for that standard improved from the previous review and a down arrow (↓) indicates the standard was scored lower than the previous review. Scores without arrows indicate that there was no change in the score from the previous review.

A. ATC, Healthy Blue, Molina, Select Health, and WellCare

Administration

42 CFR § 438.242, 42 CFR § 457.1233 (d), 42 CFR § 438.224

Standards in the Administration section cover policy and procedure management, staffing levels, compliance education and oversight, information system capabilities, and confidentiality. The CCME 2020 - 2021 EQR review for ATC, Health Blue, Molina, Select Health, and WellCare concluded that each health plan's general approach to the development, review, and disbursement of policies and procedures was consistent with the *SCDHHS Contract* and federal regulations.

Each plan's Organizational Chart documents sufficient staffing coverage to meet requirements for contractually designated roles. The organizational structure and lines of communication are clearly defined in policies and procedures, staff handbooks, and program descriptions. Training materials and compliance plans outline requirements for employees regarding reporting and management of all suspected and actual incidents of fraud, waste, and abuse. Codes of conduct and business ethics were provided by each plan and are attested to by each employee annually.

Internal auditing and monitoring procedures are used to identify areas of compliance deficiency. Plans identified units or departments that respond to reports of suspected non-compliance and assess continuing compliance. Assessments are conducted regarding the impacts and effectiveness of corrective measures implemented to address previously identified compliance deficiencies.

Compliance Committee minutes, compliance plans, and the role of the Compliance Officer were evident for each health plan. Lines of communication regarding the reporting of fraud, waste, and abuse (FWA) were clearly defined. Training and education about general policies and compliance and ethics attestation is a collaborative effort between Human Resources and the Compliance Department. Each health plan has policies specific to confidentiality, which stipulate that all associates have a responsibility for appropriate use and disclosure of member Protected Health Information.

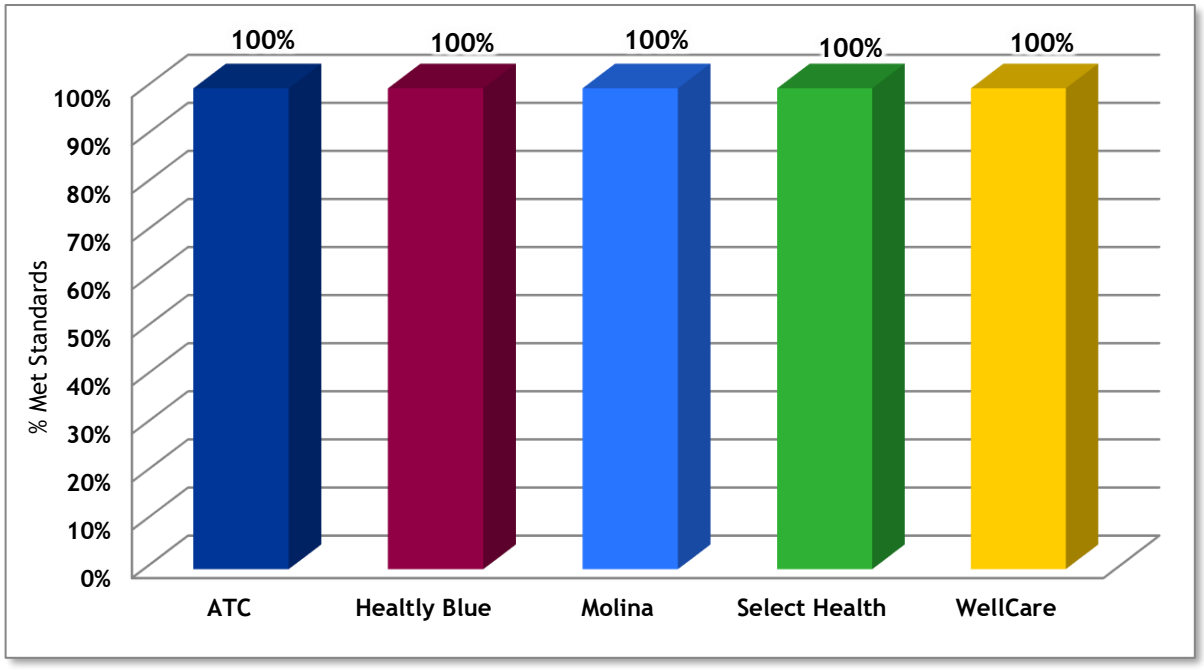
Information Systems Capabilities Assessment

42 CFR § 438.242, 42 CFR § 457.1233 (d)

The Information System Capabilities Assessment (ISCA) documentation provided a clear overview of systems, processes, and polices that are in place. The MCOs process provider claims in an accurate and timely fashion. The organizations' security plans contain bolstered policies and procedures that address the tasks necessary to maintain that security posture. The plans have disaster recovery and business continuity plans to ensure data and systems are operational in the event of an outage. Policies and procedures appear to be frequently reviewed and updated based upon each document's change log timestamps.

As noted in *Figure 2: Administration*, each of the MCOs achieved scores of "Met" for 100% of the standards in the Administration section.

Figure 2: Administration



An overview of the scores for the Administration section is illustrated in *Table 11: Administration Comparative Data*. The table also indicates strengths, weaknesses, and recommendations related to quality, timeliness, and access to care.

Table 11: Administration Comparative Data

Standard	ATC	Healthy Blue	Molina	Select Health	WellCare	▶ = *Quality* ▶ = *Timeliness* ▶ = *Access to Care*
General Approach to Policies and Procedures						
The MCO has in place policies and procedures that impact the quality of care provided to members, both directly and indirectly	Met	Met	Met	Met	Met	**Strength:** ▶ Health plans demonstrated that regular reviews and revisions occur to ensure that policies and procedures meet state and federal guidelines
Organizational Chart / Staffing						
The MCO's resources are sufficient to ensure that all health care products and services required by the State of South Carolina are provided to members. At a minimum, this includes designated staff performing in the following roles: *Administrator (CEO, COO, Executive Director)	Met	Met	Met	Met	Met	**Strength:** ▶ Staffing requirements for state-specific positions are clearly denoted on each plan's Organizational Chart.
Chief Financial Officer (CFO)	Met	Met	Met	Met	Met	
*Contract Account Manager	Met	Met	Met	Met	Met	
Information Systems personnel Claims and Encounter Manager/ Administrator	Met	Met	Met	Met	Met	
Network Management Claims and Encounter Processing Staff	Met	Met	Met	Met	Met	
Utilization Management (Coordinator, Manager, Director)	Met	Met	Met	Met	Met	
Pharmacy Director	Met	Met	Met	Met	Met	

Standard	ATC	Healthy Blue	Molina	Select Health	WellCare	▶ = *Quality* ▶ = *Timeliness* ▶ = *Access to Care*
Utilization Review Staff	Met	Met	Met	Met	Met	
*Case Management Staff	Met	Met	Met	Met	Met	
*Quality Improvement (Coordinator, Manager, Director)	Met	Met	Met	Met	Met	
Quality Assessment and Performance Improvement Staff	Met	Met	Met	Met	Met	
*Provider Services Manager	Met	Met	Met	Met	Met	
*Provider Services Staff	Met	Met	Met	Met	Met	
*Member Services Manager	Met	Met	Met	Met	Met	
Member Services Staff	Met	Met	Met	Met	Met	
*Medical Director	Met	Met	Met	Met	Met	
*Compliance Officer	Met	Met	Met	Met	Met	
Program Integrity Coordinator	Met	Met	Met	Met	Met	
Compliance /Program Integrity Staff	Met	Met	Met	Met	Met	
*Interagency Liaison	Met	Met	Met	Met	Met	
Legal Staff	Met	Met	Met	Met	Met	

Standard	ATC	Healthy Blue	Molina	Select Health	WellCare	▶ = *Quality* ▶ = *Timeliness* ▶ = *Access to Care*
Board Certified Psychiatrist or Psychologist	Met	Met	Met	Met	Met	
Post-payment Review Staff	Met	Met	Met	Met	Met	
Operational relationships of MCO staff are clearly delineated	Met	Met	Met	Met	Met	
Management Information Systems *42 CFR § 438.242, 42 CFR § 457.1233 (d)*						
The MCO processes provider claims in an accurate and timely fashion	Met	Met	Met	Met	Met	
The MCO is capable of accepting and generating HIPAA compliant electronic transactions	Met	Met	Met	Met	Met	
The MCO tracks enrollment and demographic data and links it to the provider base	Met	Met	Met	Met	Met	
The MCO's management information system is sufficient to support data reporting to the State and internally for MCO quality improvement and utilization monitoring activities	Met	Met	Met	Met	Met	
The MCO has policies, procedures and/or processes in place for addressing data security as required by the contract	Met	Met	Met	Met	Met	
The MCO has policies, procedures and/or processes in place for addressing system and information security and access management	Met	Met	Met	Met	Met	
The MCO has a disaster recovery and/or business continuity plan that has been tested, and the testing has been documented	Met	Met	Met	Met	Met	

Standard	ATC	Healthy Blue	Molina	Select Health	WellCare	▶ = *Quality* ▶ = *Timeliness* ▶ = *Access to Care*
Compliance/Program Integrity						
The MCO has a Compliance Plan to guard against fraud and abuse	Met	Met	Met	Met	Met	**Strength:** ▶ Guidelines for recognizing and reporting compliance, FWA, confidentiality, conduct, and quality of services were evident for each plan.
The Compliance Plan and/or policies and procedures address all requirements	Met	Met	Met	Met	Met	
The MCO has an established committee responsible for oversight of the Compliance Program	Met	Met	Met	Met	Met	
The MCO's policies and procedures define processes to prevent and detect potential or suspected fraud, waste, and abuse	Met	Met	Met	Met	Met	
The MCO's policies and procedures define how investigations of all reported incidents are conducted	Met	Met	Met	Met	Met	
The MCO has processes in place for provider payment suspensions and recoupments of overpayments	Met	Met	Met	Met	Met	
The MCO implements and maintains a statewide Pharmacy Lock-In Program (SPLIP)	Met	Met	Met	Met	Met	
Confidentiality *42 CFR § 438.224*						
The MCO formulates and acts within written confidentiality policies and procedures that are consistent with state and federal regulations regarding health information privacy	Met	Met	Met	Met	Met	

Provider Services

42 CFR § 438.206 through § 438.208, 42 CFR § 438.214, 42 CFR § 438.236, 42 CFR § 438.414, 42 CFR § 457.1230(a), 42 CFR § 457.1230(b), 42 CFR § 457.1230(c), 42 CFR § 457.1233(a), 42 CFR § 457.1233(c), 42 CFR § 457.1260

Included in the review of Provider Services are policies and procedures, credentialing and recredentialing processes and files, adequacy and accessibility of provider networks, processes for provider education, processes for assessing provider medical record documentation, and preventive health and clinical practice guidelines.

Credentialing and Recredentialing

42 CFR § 438.214, 42 CFR § 457.1233(a)

Each of the health plans has policies and procedures detailing provider credentialing and recredentialing processes. CCME recommended that Healthy Blue revise two policies to indicate that National Committee for Quality Assurance (NCQA) credentialing and recredentialing standards are followed. During the previous reviews, issues were identified with documentation, including omission of the process for ensuring all individuals and entities in the network are enrolled with SCDHHS as Qualified Medicaid Providers (Healthy Blue); errors in and/or lack of documentation of the timeframe for processing credentialing and recredentialing applications (Healthy Blue); and lack of documentation related to performing federal and state database checks for persons identified with an ownership or controlling interest (WellCare). Both health plans adequately addressed these findings by revising policies, program descriptions, etc.

The MCOs have established committees that use a peer-review process when considering whether to approve a provider for inclusion in the provider network. These committees are chaired by health plan medical directors, and members include network providers with an array of specialties. CCME noted ATC's external committee membership included only providers with specialties of Surgery, Pediatrics, and Psychiatry. CCME recommended that ATC consider adding at least one adult medicine provider, such as an Internist or Family Practitioner, to its committee. The committees meet regularly; however, discrepancies were noted in Healthy Blue's documentation of the meeting frequency. A recommendation was offered to revise the applicable documents to correctly document the meeting frequency. Documentation of the quorum for the committee was not found for Healthy Blue and WellCare, with a recommendation provided to document the quorum in an appropriate document.

For the current EQR, a sample of provider credentialing and recredentialing files was reviewed for each MCO. Issues identified included:

- Lack of evidence of query of the Social Security Administration's Death Master File at initial credentialing (Select Health).

- Lack of evidence that Clinical Laboratory Improvement Amendments (CLIA) certification for all practice locations was verified at initial credentialing and/or recredentialing (Healthy Blue, Select Health).
- CLIA verification that occurred outside of the timeframe stated in policy, after the credentialing decision, and for a different practice location (Select Health).

In addition, Recredentialing Checklists in some of Molina's recredentialing files contained unclear documentation regarding whether the providers were checked against exclusion and sanction databases. Molina's process was explained during the onsite and a recommendation was given to clarify the checklist going forward.

For the previous EQR, issues were identified in all of the MCOs' initial credentialing and recredentialing files. These issues were related to lack of evidence of required queries, incomplete provider applications, missing CLIA verifications, outdated Ownership Disclosure forms, untimely primary source verification, and outdated nurse practitioner collaborative agreements. The applicable health plans implemented Quality Improvement Plans (QIPs) to address the identified issues by updating processes and creating a Lead position within the Organizational Assessment Team to perform Quality reviews (ATC); ensuring staff have access to the Social Security Death Master File (Healthy Blue); revising processes for CLIA verification and collection of Ownership Disclosure forms (WellCare).

Tables 12, 13, and 14 below provide the previous EQR findings related to credentialing and recredentialing, and the plans' responses to those findings.

Table 12: Previous Credentialing and Recredentialing QIPs for ATC

Standard	EQR Comments
II A. Credentialing and Recredentialing	
3.1.10 Query of the State Excluded Provider's Report and the SC Providers Terminated for Cause List	None of the practitioner credentialing files (16) contained the date the SCDHHS Terminated for Cause List was queried. *Quality Improvement Plan: Ensure credentialing files contain proof that the SCDHHS Terminated for Cause List was queried.*
ATC Response: ATC has updated our process to include a header in the SCDHHS Terminated for Cause List upon receipt so that the date is clearly identified in the report for each query.	
3.1.15 Clinical Laboratory Improvement Amendment (CLIA) Certificate (or certificate of waiver) for providers billing laboratory procedures;	Four credentialing files did not contain copies of the Clinical Laboratory Improvement Amendment (CLIA) certificate even though the provider indicated on the application that laboratory services were provided at locations where they currently practice. This was discussed during the onsite and ATC indicated some provider locations (2 files) were considered nonparticipating locations. Screen

Standard	EQR Comments
	shots were provided indicating the locations were not entered in the Portico system. *Quality Improvement Plan: Ensure that a copy of the CLIA Certificate is obtained for all practice locations noted as providing laboratory services.*
ATC Response: ATC will ensure that a copy of the CLIA certificate is obtained for all practice locations noted as providing laboratory services. If we are unable to obtain a CLIA for non-participating locations, we will include documentation of the attempt to collect, and clearly note the non-par location.	
4.2.9 Requery of the State Excluded Provider's Report and the SC Providers Terminated for Cause List	Three recredentialing files did not show evidence the SCDHHS Excluded Provider List was queried. Quality Improvement Plan: Ensure recredentialing files contain proof that the SCDHHS Excluded Provider List was queried.
ATC Response: ATC has updated our process to include a header in the SCDHHS Terminated for Cause List upon receipt so that the date is clearly identified in the report for each query.	
4.2.14 Clinical Laboratory Improvement Amendment (CLIA) Certificate for providers billing laboratory procedures.	Seven recredentialing files did not contain copies of the Clinical Laboratory Improvement Amendment (CLIA) certificate even though the provider indicated on the application that laboratory services were provided at locations where they currently practice. *Quality Improvement Plan: Ensure that a copy of the CLIA Certificate is obtained for all practice locations noted as providing laboratory services.*
ATC Response: ATC will ensure that a copy of the CLIA certificate is obtained for all practice locations noted as providing laboratory services. If we are unable to obtain a CLIA for non-participating locations, we will include documentation of the attempt to collect, and clearly note the non-par location.	
6. Organizational providers with which the MCO contracts are accredited and/or licensed by appropriate authorities.	Issues identified with the organizational credentialing files included: • One file did not contain a copy of the facility's CMS certification. The CMS certification provided was for a different facility. • A copy of the facilities license was not provided for 2 facility files. • The SCDHHS Excluded Provider List query for one facility was more than a year old. • The date of verification for one facility's NPI number was missing. • The ownership disclosure form for one facility was not dated. *Quality Improvement Plan: Develop a plan to monitor the credentialing files for organizational providers to ensure all requirements are met.*
ATC Response: ATC has a checklist in place for our Credentialing Specialists which includes detail of all regulatory requirements. We will ensure that each staff member who processes cred and recred files reviews the checklist prior to completion to ensure all documents are up to date. We have also recently created a Lead position within the Organizational Assessment team to perform Quality reviews.	

Table 13: Previous Credentialing and Recredentialing QIPs for Healthy Blue

Standard	EQR Comments
II A. Credentialing and Recredentialing	
1. The MCO formulates and acts within policies and procedures related to the credentialing and recredentialing of health care providers in a manner consistent with contractual requirements.	Processes for provider credentialing and recredentialing are found in the Healthy Blue Credentialing Program Plan (Credentialing Plan), Policy MCD – 04, Initial Credentialing, Policy MCD – 05, Recredentialing, and Policy MCD – 06, Health Care Delivery Organizations – Credentialing / Recredentialing. During review of these documents, CCME could not identify the process for ensuring all individuals and entities in the network are enrolled with SCDHHS as Qualified Medicaid Providers. Refer to the *SCDHHS Contract, Section 2.8.1.1.* Discussion with Healthy Blue staff revealed the timeframe for processing credentialing and recredentialing applications is within 30 days of receipt of a completed application. Regarding this timeframe, the following issues were noted: •The Credentialing Plan, page 2, references the timeframe as 90 days. •Policy MCD-04, page 7, states the timeframe is 60 days for denied applications and does not reference the overall timeframe for approved applications. •The timeframe is not documented in Policy MCD –05 and Policy MCD – 06. ***Quality Improvement Plan: Update the documents above to include the process for ensuring all individuals and entities in the network are enrolled with SCDHHS as Qualified Medicaid Providers. Ensure the correct timeframe for processing complete credentialing and recredentialing applications is included in the Credentialing Plan, Policy MCD-04, Policy MCD -05, and Policy MCD – 06.***
Healthy Blue Response: Policy MCD-04, page 6, has been updated to state, "Review and determination by the Credentialing Committee will take place within 30 days after receipt of a completed initial credentialing application." Policy MCD-05, page 2, has been updated to state, "Applications are completed prior to the 36 month expiration date." Policy MCD-06, page 2, has been updated to state, "Review and determination by the Credentialing Committee will take place within 30 days after receipt of a completed initial credentialing application." MCD-04 (page 2), MCD-05 (page 3), and MCD-06 (page 2) have been updated to include obtaining a current Medicaid ID number as a part of the credentialing criteria and process for ensuring all individuals and entities in the network are enrolled with SCDHHS as Qualified Medicaid Providers. The Credentialing Program Description, page 3 has been updated to state, "Inclusion of the Medicaid ID number on the application prior to performing credentialing or recredentialing." It was also updated to indicate the process for reviewing credentialing applications is completed within 30 days of receipt of an application.	
3.1.12 Query of Social Security Administration's Death Master File (SSDMF);	Of 16 initial provider credentialing files, only three contained evidence that the Social Security Death Master File (SSDMF) was queried. Healthy Blue submitted a memo indicating there have been technical issues with obtaining the SSDMF information since June 2019. Attempts to resolve these issues have been unsuccessful thus

Standard	EQR Comments
	far. However, for the three files that did provide evidence of querying the SSDMF, the queries were conducted after June 2019. ***Quality Improvement Plan: Ensure each provider credentialing file reflects that the SSDMF has been queried, as required by the SCDHHS Contract, Section 11.2.10, and the SCDHHS Policy and Procedure Guide for Managed Care Organizations, Section 11.2.***
Healthy Blue Response: Our access to the Social Security Death Master File has been restored. We have resumed processing Death Master File queries for all Initial Credentialing and Recredentialing files.	
4.2.11 Query of the Social Security Administration's Death Master File (SSDMF);	Of 17 recredentialing files for providers, only three contained evidence that the Social Security Death Master File (SSDMF) was queried. Healthy Blue submitted a memo indicating there have been technical issues with obtaining the SSDMF information since June 2019. Attempts to resolve these issues have been unsuccessful thus far. However, for the three files that did provide evidence of querying the SSDMF, the queries were conducted after June 2019. ***Quality Improvement Plan: Ensure each provider recredentialing file reflects that the SSDMF has been queried, as required by the SCDHHS Contract, Section 11.2.10, and the SCDHHS Policy and Procedure Guide for Managed Care Organizations, Section 11.2.***
Healthy Blue Response: Our access to the Social Security Death Master File has been restored. We have resumed processing Death Master File queries for all Initial Credentialing and Recredentialing files.	

Table 14: Previous Credentialing and Recredentialing QIPs for WellCare

Standard	EQR Comments
II A. Credentialing and Recredentialing	
1. The MCO formulates and acts within policies and procedures related to the credentialing and recredentialing of health care providers in a manner consistent with contractual requirements.	Policy SC22-OP-CR-009, Assessment of Organizational Providers, includes obtaining the ownership disclosure information. However, this policy omits performing federal and state database checks for persons identified on Ownership Disclosure forms with an ownership or controlling interest as required in the *SCDHHS Contract, Section 11.2.10* and the *Managed Care Organizations Policy and Procedure Guide, Section 11.2.* *Quality Improvement Plan: Update Policy SC22-OP-CR-009, Assessment of Organizational Providers to explain how WellCare performs federal and state database checks for persons identified on the Ownership Disclosure forms with an ownership or controlling interest as required in the SCDHHS Contract, Section 11.2.10 and the Managed Care Organizations Policy and Procedure Guide, Section 11.2.*

Standard	EQR Comments
WellCare Response: WellCare implemented the process to query the SC DHHS system in 2019. The EQR team verified that all sample files dated after the implementation date of the corrective action, in May 2019, included proof of the required reviews of the State identified database (SCDHHS List of Providers Terminated for Cause).	
Credentialing 3.1 Verification of information on the applicant, including: 3.1.10 Query of the State Excluded Provider's Report and the SC Providers Terminated for Cause List;	None of the credentialing files contained proof that the SCDHHS List of Providers Terminated for Cause was queried, as required by the *SCDHHS Contract, 11.2.10*. CCME identified this issue during the 2018 EQR. *Quality Improvement Plan: Implement a plan to ensure the SCDHHS List of Providers Terminated for Cause is queried for each credentialing file and proof of the query is documented in the file.*
WellCare Response: WellCare implemented the process to query the SC DHHS system in 2019. The EQR team verified that all sample files dated after the implementation date of the corrective action, in May 2019, included proof of the required reviews of the State identified database (SCDHHS List of Providers Terminated for Cause).	
Credentialing 3.1 Verification of information on the applicant, including: 3.1.15 Clinical Laboratory Improvement Amendment (CLIA) Certificate (or certificate of waiver) for providers billing laboratory procedures;	Three files did not address the Clinical Laboratory Improvement Amendment (CLIA). The applications used for credentialing did not address whether laboratory services would be provided at the practice location nor if the provider was queried about laboratory services. *Quality Improvement Plan: Ensure that a copy of the CLIA Certificate is obtained during the credentialing process. If laboratory services are not addressed in the credentialing application, query the provider to determine if a CLIA is needed.*
WellCare Response: WellCare researches CAQH for any missing CLIA information and populate the appropriate fields. If there is no CLIA information in CAQH for the provider then there is nothing to load in that field. Should future claims be submitted for lab services those claims will receive a denial consistent with missing documents and the provider would be required to submit CLIA certificate. WellCare will email and contact providers as appropriate in the event CLIAs are still missing. 3/18/2020-WellCare will be sure CLIAs are received by appropriate providers prior to submitting final packet for credentialing. In the event the CLIA is missing WellCare will contact the provider to confirm if a CLIA is required.	
Recredentialing 4.2 Verification of information on the applicant, including: 4.2.9 Requery of the State Excluded Provider's Report and the SC Providers Terminated for Cause List;	None of the recredentialing files contained proof that the SCDHHS List of Providers Terminated for Cause was queried as required by the *SCDHHS Contract, 11.2.10*. CCME identified this uncorrected issue during the 2018 EQR. *Quality Improvement Plan: Implement a plan to ensure the SCDHHS List of Providers Terminated for Cause is queried for each recredentialing file.*
WellCare Response: WellCare implemented the process to query the SC DHHS system in 2019. The EQR team verified that all sample files dated after the implementation date of the corrective action, in May 2019, included proof of the required reviews of the State identified database (SCDHHS List of Providers Terminated for Cause).	

Standard	EQR Comments
6. Organizational providers with which the MCO contracts are accredited and/or licensed by appropriate authorities.	•Six recredentialing files contained the WellCare Ownership Disclosure form instead of the required SCDHHS 1514 form. •None of the organizational credentialing and recredentialing files contained proof that the SCDHHS List of Providers Terminated for Cause List was queried. CCME identified this uncorrected issue during the 2018 EQR. *Quality Improvement Plan: Ensure the SCDHHS 1514 Ownership Disclosure form is obtained.* *Document proof of the query of the SCDHHS List of Providers Terminated for Cause in the organizational provider credentialing and recredentialing files.*
WellCare Response: WellCare implemented the process to query the SC DHHS system in 2019. The EQR team verified that all sample files dated after the implementation date of the corrective action, in May 2019, included proof of the required reviews of the State identified database (SCDHHS List of Providers Terminated for Cause). 3/18/2020-Two policies were submitted to include Ownership Disclosure language.	

Adequacy of the Provider Network

42 CFR § 438.206, 42 CFR § 438.207, 42 CFR § 438.10(h), 42 CFR § 457.1230(a) (b), 42 CFR § 457.1230(b)

The health plans' policies define provider access standards, appointment access standards, and processes for monitoring the networks' abilities to meet membership needs. Health plan policies appropriately document the access requirements for primary care providers (PCPs), specialists, and hospitals.

Methods used to monitor and evaluate network adequacy include Geo Access reports, analysis of CAHPS survey results, analysis of member complaints, "secret shopper" surveys, etc. When reviewing health plan reports of network assessments for the most recent EQR, the following issues were identified:

- For ATC, Geo Access reports (dated December 21, 2020) did not provide evidence that access was measured for General Surgery and Rehabilitative Behavioral Health Status, which are required Status 1 providers.
- Select Health of South Carolina Availability of Practitioners Report contained discrepancies in the PCP access standard and the access standard for some specialty types when comparing the report to the Availability of Practitioners policy.
- For Molina, Geo Access documentation for Q4 2020 did not include psychologists, which are a required Status 1 provider.

The previous EQR revealed that ATC omitted some required Status 1 provider types (Rehabilitative Behavioral Health and Audiology Therapy providers) in Geo Access

mapping. In responding to the QIP for this item, ATC indicated processes had been updated to add all Status 1 providers in the evaluation of network adequacy. However, the most recent EQR revealed Rehabilitative Behavioral Health providers were not included. This was a repeat finding for ATC.

For the most recent EQRs, standards and requirements for PCP and specialist appointment access were appropriately defined in policies and/or procedures. Standards documented by ATC and WellCare comply with appointment access standards from the *SCDHHS Contract, Section 6.2.2.3*. Issues were noted as follows in the remaining plans' documentation:

- Healthy Blue's Medicaid Access/Availability Standard policy did not include the requirement for PCPs related to walk-in patients with non-urgent needs.
- Molina's Provider Availability Standards procedure did not include standards for specialty emergent visits and urgent medical condition care appointments. The procedure as well as the Provider Manual incorrectly defined the timeframe for routine care specialty appointments.
- The Select Health of South Carolina Accessibility of Services Report included an incorrect appointment access timeframe for specialty providers. This was a repeat finding from the previous year's EQR.

The MCOs have established processes to ensure their network providers can serve members with special needs such as hearing or vision impairment, foreign language or cultural requirements, and complex medical needs. Included in the processes are analyses of the needs of the membership population, provider education about cultural competency, and network oversight to ensure compliance with cultural, linguistic, and disability access requirements.

CCME evaluated the MCOs' Provider Directories for compliance with state and federal requirements. No issues were identified in Select Health's and WellCare's Provider Directories. For ATC and Healthy Blue, recommendations were given for revisions to improve minor issues noted in their Provider Directories. CCME's review of Molina's printed Provider Directory and the online Provider Directory (via the "Find A Provider" function of Molina's website) revealed the required elements of provider website addresses and abilities to accommodate persons with physical disabilities were not included in the directories.

Deficiencies related to adequacy of the provider network from the previous EQRs and the health plans' responses to address the QIPs for the deficiencies are detailed in Tables 15 and 16 below.

Table 15: Previous Network Adequacy QIP for ATC

Standard	EQR Comments
II B. Adequacy of the Provider Network	
1.2 Members have access to specialty consultation from a network provider located within reasonable traveling distance of their homes. If a network specialist is not available, the member may utilize an out-of-network specialist with no benefit penalty.	ATC provided GEO Access Reports reflecting evaluation of network provider access for most Status 1 providers. CCME could not identify in submitted information that ATC measures geographic access for Rehabilitative Behavioral Health providers and Audiology Therapy providers. This information was requested from ATC during the onsite but was not provided. Because these provider types are listed as Status 1 providers in SCDHHS' Policy and Procedure Guide for Managed Care Organizations, they should be included in the Plan's geographic access evaluations. *Quality Improvement Plan: Ensure all Status 1 providers are included in evaluations of network adequacy.*
ATC Response: ATC has ensured to update its process to add all Status 1 providers (Rehabilitative Behavioral Health and Audiology Therapy), as requested in the evaluation of the Network Adequacy. In ATC's most recent Network review/submission with SCDHHS the Network was deemed sufficient in all counties.	

Table 16: Previous Network Adequacy QIP for Select Health

Standard	EQR Comments
II B. Adequacy of the Provider Network	
3. Practitioner Accessibility 3.1 The MCO formulates and ensures that practitioners act within written policies and procedures that define acceptable access to practitioners and that are consistent with contract requirements.	Page two of Policy NM 159.203, Accessibility of Services / After Hours Survey and High Volume High Impact Survey states the standard appointment access requirement for High-Volume/High-Impact specialists for routine visits is four to 12 weeks, matching the requirement in the *SCDHHS Contract, Section 6.2.3.1.5.3*. However, the following issues were noted: •*Attachment B* (page 6) of Policy NM 159.203 lists the requirement for routine visits as six to eight weeks. •Documentation in the *Quality Assessment and Performance Improvement: 2018 Program Evaluation* shows access to High-Volume/High-Impact specialists was measured using a standard of six to eight weeks for routine care appointments. •This six- to eight-week timeframe is also documented in the *Appointment Accessibility for PCP and High Volume and High Impact Providers Report* dated October 9, 2019. Policy NM 159.306, Accessibility of Behavioral Healthcare Services and the *2019 Behavioral Health Access Survey Report* list the goal for appointment access standards for Behavioral Healthcare Services as 90% compliance. However, documentation in the *Quality Assessment*

Standard	EQR Comments
	and Performance Improvement: 2018 Program Evaluation shows the goal is 95%. *Quality Improvement Plan: Revise Attachment B of Policy NM 159.203 to include the correct parameters for routine appointment access (four to 12 weeks) for High-Volume/High-Impact specialists. Refer to the SCDHHS Contract, Section 6.2.3.1.5.3. Ensure the correct parameters are used for measuring provider compliance and reported in future Quality Assessment and Performance Improvement: Program Evaluations and Appointment Accessibility for PCP and High-Volume and High-Impact Providers reports.*
Select Health Response: The policy NM 159.203 has been revised to update the standard for routine visits to four (4) to six (6) weeks from four (4) to twelve (12) weeks. The routine, established patient section under High Impact/High volume appointment access standards was revised to show the standard is within four (4) to twelve (12) week maximum. Please see revision below and the attached policy approved by the Policy and Procedure team on 01/09/2020. The QAPI Program evaluation has been revised to reflect the appointment access standards as 90% compliance. See redline version of the changes below and attached. In addition, the QAPI Program evaluation's access to High Volume/High Impact Specialist section has been revised to four (4) to twelve (12) week maximum. See redline version of these changes below and attached.	

Provider Access and Availability Study.

42 CFR § 438.206(c)(1), 42 CFR § 457.1230(a), 42 CFR § 457.1230(b)

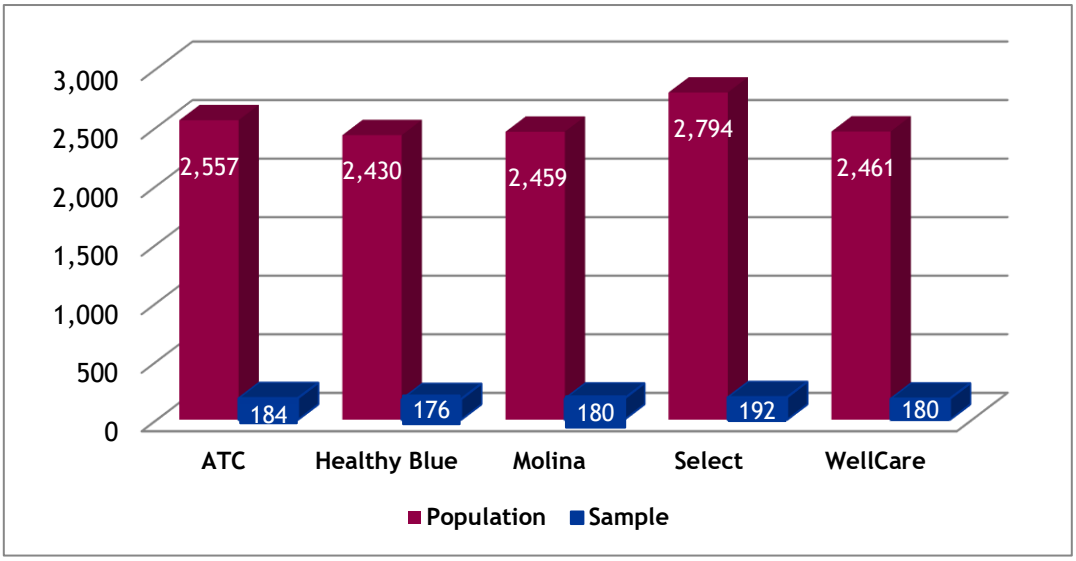
As a part of the annual review process for all plans, CCME performed a Telephonic Provider Access Study focusing on PCPs. CCME requested and received a list of network providers and contact information from each of the health plans. From each list, CCME defined a population of PCPs and selected a statistically relevant sample of providers for the study. CCME attempted to contact these providers to ask a series of questions about the access plan members have to their PCPs.

One plan received a score of "Met" and the other four plans received a score of "Not Met" for the standard requiring an improvement in the results of the Telephonic Provider Access Study. The following charts summarize CCME's Provider Access and Availability Study findings and compare the five plans surveyed.

Population and Sample Size

From the five MCOs reviewed, CCME identified a total population of 12,701 PCPs. From each plan's population, CCME drew a random sample and selected a total of 912 providers, as shown in *Figure 3: Population and Sample Sizes for Each Plan*.

Figure 3: Population and Sample Sizes for Each Plan



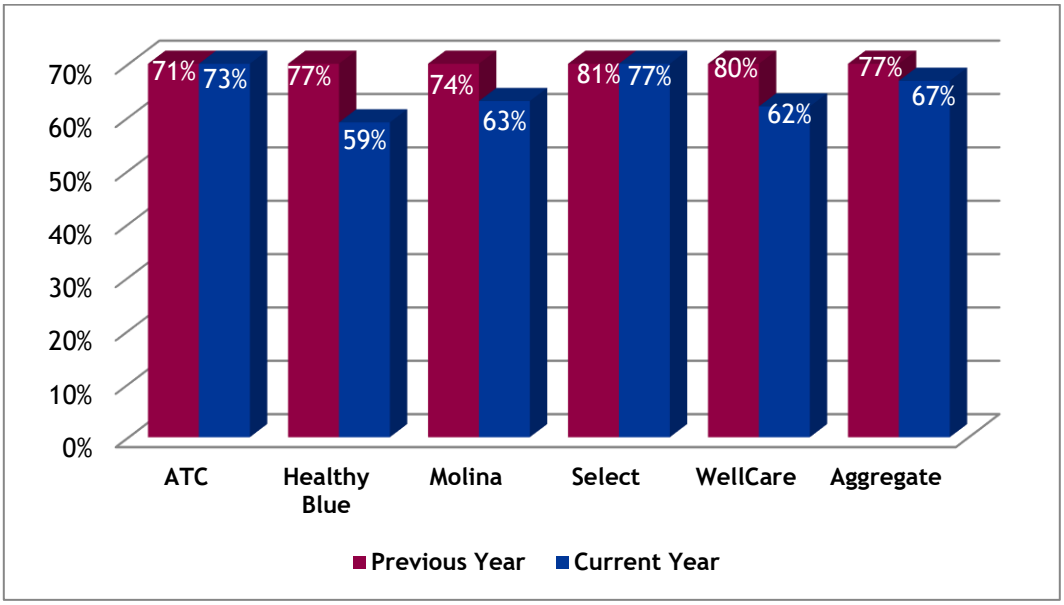
Successfully Answered Calls

Using the telephone contact information provided by the plans, CCME called each provider to ask a series of questions. CCME calculated the success rate as follows:

- Success Rate: number of calls answered / (total number of calls - calls answered by a general or personal voicemail service)

In aggregate, the providers answered 67% of the calls successfully (see *Figure 4: Percentage of Successfully Answered Calls*), a 10% decrease from the previous review cycle rate of 77%. One plan showed improvement in the success rate, and the other four plans had a decline in success rate. Of the four plans with a decline in the success rate, one plan had a non-statistically significant decline, and the other three had statistically significant declines ($p < .05$) in their success rates when evaluated using Fisher's exact tests.

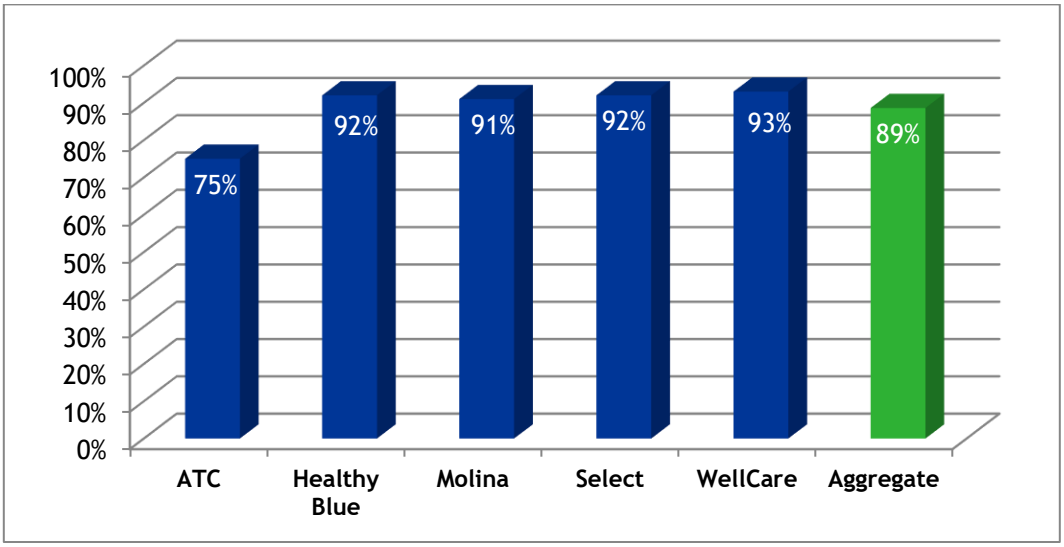
Figure 4: Percentage of Successfully Answered Calls



Currently Accepting the Plan

Of the calls successfully answered, 89% responded that the provider accepts the respective health plan, representing a three-percentage point decrease from the previous year's rate of 92%. *Figure 5: Percentage of Providers Accepting the Plan*, displays the percentage of providers that indicated they accept the plan.

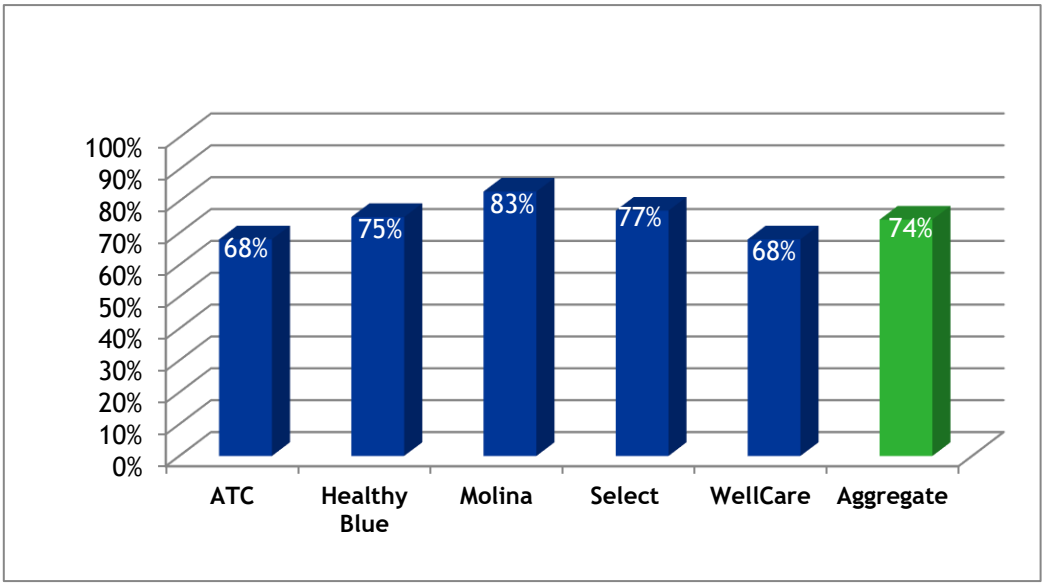
Figure 5: Percentage of Providers Accepting the Plan



Accepting Medicaid Patients

In aggregate, 74% of the providers accepting the plan responded that they are accepting new Medicaid patients, which is an eight-percentage point increase from last year's rate of 66% (see *Figure 6: Percentage of Providers Accepting Medicaid Patients*). Individual plan results range from 68% to 83%.

Figure 6: Percentage of Providers Accepting Medicaid Patients



Summary of Study Findings

For the five plans, overall access to providers improved for only one plan, and access declined from the previous cycle for four plans, as indicated by the changes in the percentage of successfully answered calls in the Telephonic Provider Access Study.

The percentage of providers that are currently accepting the plan (89%) is a decrease from last year's rate of 92%. However, the study revealed an 8% increase in providers accepting new Medicaid patients when compared to last year's rate. One plan met the standard for improvement from the previous Telephonic Provider Access Study results and four plans did not meet the standard for improvement.

Established policies and procedures guide initial and ongoing provider education activities by each health plan. Newly contracted providers are oriented to the health plans and receive comprehensive information about topics such as billing and reimbursement, member benefits, referral procedures, accessibility standards, standards of care, medical record handling and documentation, etc. Ongoing provider education is provided to ensure providers are kept up to date on policies, processes, requirements, etc. The

MCOs' Provider Manuals and websites serve as readily accessible resources for providers, and each MCO has provider representatives to assist providers as needed. Issues identified resulting in recommendations and/or QIPs for the health plans included:

- ATC Provider Manual did not include all appointment access standards for specialists.
- Healthy Blue's Provider Manual omitted information that members in waiver services are not subjected to copayments and did not include the specific medical record documentation standards to which providers must comply.
- WellCare's Provider Manual and Member Handbook contained discrepancies in member benefit information.

Preventive Health Guidelines (PHGs) and Clinical Practice Guidelines (CPGs) are adopted by the MCOs to assist practitioners and members in making decisions about appropriate health care. Each of the plans includes network providers in processes for selecting, adopting, and ongoing review of the PHGs and CPGs. Network providers are educated about PHGs and CPGs in various ways, including via Provider Manuals, plan websites, provider orientation and education sessions, newsletters, etc. Healthy Blue's Clinical Practice Guidelines - Review, Adoption and Distribution policy incorrectly stated the frequency for review of CPGs. WellCare's website included retired guidelines and had not been updated to reflect the guidelines that were in use at the time.

For most of the plans, network providers are educated about standards and requirements for medical record documentation in various ways, including provider orientation and education sessions, Provider Manuals, and plan websites. However, Healthy Blue's Provider Manual did not include the medical record documentation standards and did not direct the reader to the standards elsewhere, such as on the website. Healthy Blue was unable to explain how and when providers are educated about medical record documentation standards.

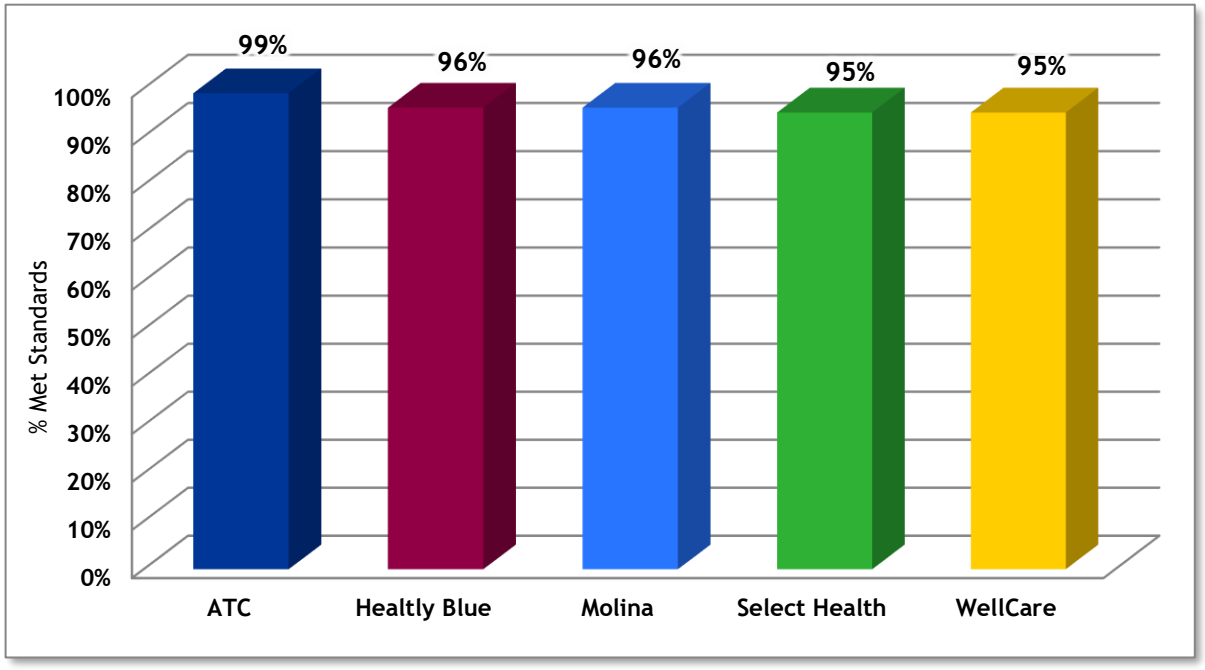
The MCOs evaluate provider compliance with the medical record documentation standards through routine medical record audits. Minor issues were found during review of the plans' policies and procedures, including failure to include a referenced attachment containing the Medical Record Audit Tool in a procedure (Molina), failure to document the process and timeframe for reaudits of providers who do not achieve a passing score for the initial medical record audit (Molina), and incorrect information about the results of the 2019 Medical Record Review Audit in the 2019 Medicaid Quality Improvement Program Evaluation (WellCare).

All of the MCOs monitor continuity and coordination of care between the PCPs and other providers, primarily through medical record review but also through analysis of member complaint, grievance, appeal, and PCP change requests; member and provider surveys;

review of quality-of-care concerns; etc. The plans analyze findings and use the information to address barriers and develop interventions to improve coordination of care.

The percentages of "Met" scores achieved by each plan for the Provider Services section of the review are illustrated in *Figure 7: Provider Services*.

Figure 7: Provider Services



An overview of the scores for the Provider Services section is illustrated in *Table 17: Provider Services Comparative Data*. The table also indicates strengths, weaknesses, and recommendations related to quality, timeliness, and access to care.

Table 17: Provider Services Comparative Data

Standard	ATC	Healthy Blue	Molina	Select Health	WellCare	▶ = *Quality* ▶ = *Timeliness* ▶ = *Access to Care*
Credentialing and Recredentialing *42 CFR § 438.214, 42 CFR § 457.1233(a)*						
The MCO formulates and acts within policies and procedures related to the credentialing and recredentialing of health care providers in a manner consistent with contractual requirements	Met	Met ↑	Met	Met	Met ↑	**Strength:** ▶ Health plan policies appropriately document processes and requirements for provider credentialing and recredentialing activities. **Weaknesses:** ▶ ATC's Credentialing Committee does not include a general adult medicine practitioner, such as a Family Practitioner or Internist. ▶ Healthy Blue's Credentialing Committee meets monthly; however, the Credentialing Program Plan contained errors in documentation of the meeting frequency. The Provider Credentialing/Recredentialing Charter does not define the quorum for Credentialing Committee meetings. ▶ WellCare materials did not specify the quorum for its Credentialing Committee. ▶ For Healthy Blue, several credentialing and/or recredentialing files did not reflect verification of Clinical Laboratory Improvement Amendments (CLIA) certificates for all provider practice locations. ▶ For many Select Health credentialing and/or recredentialing files, there was no evidence of primary source verification (PSV) of
Decisions regarding credentialing and recredentialing are made by a committee meeting at specified intervals and including peers of the applicant. Such decisions, if delegated, may be overridden by the MCO	Met	Met	Met	Met	Met	
The credentialing process includes all elements required by the contract and by the MCO's internal policies.	Met	Met	Met	Met	Met	
Verification of information on the applicant, including: Current valid license to practice in each state where the practitioner will treat members	Met	Met	Met	Met	Met	
Valid DEA certificate and/or CDS certificate	Met	Met	Met	Met	Met	
Professional education and training, or board certification if claimed by the applicant	Met	Met	Met	Met	Met	
Work history	Met	Met	Met	Met	Met	
Malpractice claims history	Met	Met	Met	Met	Met	
Formal application with attestation statement delineating any physical or mental health problem affecting ability to provide health care, any history of chemical dependency/ substance abuse, prior loss of license, prior felony	Met	Met	Met	Met	Met	

Standard	ATC	Healthy Blue	Molina	Select Health	WellCare
convictions, loss or limitation of practice privileges or disciplinary action, the accuracy and completeness of the application					
Query of the National Practitioner Data Bank (NPDB)	Met	Met	Met	Met	Met
Not debarred, suspended, or excluded from Federal procurement activities: Query of System for Award Management (SAM)	Met	Met	Met	Met	Met
Query for state sanctions and/or license or DEA limitations (State Board of Examiners for the specific discipline)	Met	Met	Met	Met	Met
Query of the State Excluded Provider's Report and the SC Providers Terminated for Cause list	Met ↑	Met	Met	Met	Met ↑
Query for Medicare and/or Medicaid sanctions (5 years); OIG List of Excluded Individuals and Entities (LEIE)	Met	Met	Met	Met	Met
Query of Social Security Administration's Death Master File (SSDMF)	Met	Met ↑	Met	Partially Met ↓	Met
Query of the National Plan and Provider Enumeration System (NPPES)	Met	Met	Met	Met	Met
In good standing at the hospital designated by the provider as the primary admitting facility	Met	Met	Met	Met	Met
Clinical Laboratory Improvement Amendment (CLIA) Certificate (or certificate of waiver) for providers billing laboratory procedures	Met ↑	Partially Met ↓	Met	Met	Met ↑
Receipt of all elements prior to the credentialing decision, with no element older than 180 days	Met	Met	Met	Met	Met

▶ = *Quality*
▶ = *Timeliness*
▶ = *Access to Care*

provider CLIA certificates, the PSV of the CLIAs occurred after the recredentialing decision date, and/or the PSV of the CLIA occurred more than 120 days prior to the recredentialing decision date. In one file, the PSV of the CLIA was for a different address.

▶ Some of Select Health's credentialing and/or recredentialing files were missing a query of the Social Security Administration's Death Master File or did not contain clear evidence that the query of the Social Security Administration's Death Master File was conducted against the provider's Social Security Number.

Recommendations:

- The plans should ensure Credentialing Committees include a general adult medicine practitioner, such as a Family Practitioner or Internist, that committee meeting frequency is clearly and consistently documented, and that the quorum for the committee is also documented.
- Ensure all credentialing and recredentialing requirements are met, including verification of CLIA certificates for all provider practice locations within the appropriate timeframe and for the correct provider address. Ensure all providers are queried against the Social

Standard	ATC	Healthy Blue	Molina	Select Health	WellCare	▶ = *Quality* ▶ = *Timeliness* ▶ = *Access to Care*
The recredentialing process includes all elements required by the contract and by the MCO's internal policies	Met	Met	Met	Met	Met	Security Administration's Death Master File using the providers Social Security Number.
Recredentialing conducted at least every 36 months	Met	Met	Met	Met	Met	
Verification of information on the applicant, including: Current valid license to practice in each state where the practitioner will treat members	Met	Met	Met	Met	Met	
Valid DEA certificate and/or CDS certificate	Met	Met	Met	Met	Met	
Board certification if claimed by the applicant	Met	Met	Met	Met	Met	
Malpractice claims since the previous credentialing event	Met	Met	Met	Met	Met	
Practitioner attestation statement	Met	Met	Met	Met	Met	
Requery the National Practitioner Data Bank (NPDB)	Met	Met	Met	Met	Met	
Requery of System for Award Management (SAM)	Met	Met	Met	Met	Met	
Requery for state sanctions and/or license or DEA limitations (State Board of Examiners for the specific discipline)	Met	Met	Met	Met	Met	
Requery of the State Excluded Provider's Report, the SC Providers Terminated for Cause list	Met ↑	Met	Met	Met	Met ↑	
Requery for Medicare and/or Medicaid sanctions since the previous credentialing event; OIG List of Excluded Individuals and Entities (LEIE)	Met	Met	Met	Met	Met	
Query of the Social Security Administration's Death Master File (SSDMF)	Met	Met ↑	Met	Met	Met	
Query of the National Plan and Provider Enumeration System (NPPES)	Met	Met	Met	Met	Met	

Standard	ATC	Healthy Blue	Molina	Select Health	WellCare	▶ = *Quality* ▶ = *Timeliness* ▶ = *Access to Care*
In good standing at the hospitals designated by the provider as the primary admitting facility	Met	Met	Met	Met	Met	
Clinical Laboratory Improvement Amendment (CLIA) Certificate for providers billing laboratory procedures	Met ↑	Partially Met ↓	Met	Not Met ↓	Met	
Review of practitioner profiling activities	Met	Met	Met	Met	Met	
The MCO formulates and acts within written policies and procedures for suspending or terminating a practitioner's affiliation with the MCO for serious quality of care or service issues	Met	Met	Met	Met	Met	
Organizational providers with which the MCO contracts are accredited and/or licensed by appropriate authorities	Met ↑	Met	Met	Met	Met ↑	
Monthly provider monitoring is conducted by the MCO to ensure providers are not prohibited from receiving Federal funds	Met	Met	Met	Met	Met	
Adequacy of the Provider Network *42 CFR § 438.206, 42 CFR § 438.207, 42 CFR § 438.10(h), 42 CFR § 457.1230(a) (b), 42 CFR § 457.1230(b)*						
The MCO maintains a network of providers that is sufficient to meet the health care needs of members and is consistent with contract requirements. Members have a primary care physician located within a 30-mile radius of their residence	Met	Met	Met	Met	Met	**Strengths:** ▶ All health plans have established processes for ongoing monitoring and assessment of their provider networks. ▶ If network gaps are identified, plans begin recruiting to fill the gaps. Single case agreements are implemented as needed for members to see out-of-network providers when a network provider is not available.
Members have access to specialty consultation from a network provider located within reasonable traveling distance of their homes. If a network specialist is not available, the member	Met ↑	Met	Met	Met	Met	

Standard	ATC	Healthy Blue	Molina	Select Health	WellCare	▶ = *Quality* ▶ = *Timeliness* ▶ = *Access to Care*
may utilize an out-of-network specialist with no benefit penalty						**Weaknesses:** ▶ Geo Access reports for ATC and Molina did not include all required Status 1 provider types. ▶ Select Health's South Carolina Availability of Practitioners Report included errors in documentation of the required access parameters for several provider types that were inconsistent with the plan's policy. ▶ Results of the Provider Access and Availability Studies for four plans demonstrated a decrease in the rate of providers successfully contacted. Overall, a decrease in the rate of providers that reported they accepted the health plans was noted. ▶ ATC's online "Find a Provider Tool" did not include the required statement that some providers may choose not to perform certain services based on religious or moral beliefs. ▶ Molina's Provider Directory was missing the required elements of provider website addresses and whether providers can accommodate physical disabilities. **Recommendations:** • Ensure network assessments include all Status 1 provider types and that correct parameters are documented and used for time/distance measurement. • Review and revise Provider Directories as needed to include all required elements.
The sufficiency of the provider network in meeting membership demand is formally assessed at least bi-annually	Partially Met ↓	Met	Met	Met	Met	
Providers are available who can serve members with special needs such as hearing or vision impairment, foreign language/cultural requirements, and complex medical needs	Met	Met	Met	Met	Met	
The MCO demonstrates significant efforts to increase the provider network when it is identified as not meeting membership demand	Met	Met	Met	Met	Met	
The MCO maintains a provider directory that includes all requirements outlined in the contract	Met	Met	Partially Met ↓	Met	Met	
The MCO formulates and ensures that practitioners act within written policies and procedures that define acceptable access to practitioners and that are consistent with contract requirements	Met	Met	Partially Met ↓	Not Met ↓	Met	
The Telephonic Provider Access Study conducted by CCME shows improvement from the previous study's results	Met	Not Met ↓	Not Met ↓	Not Met ↓	Not Met ↓	

Standard	ATC	Healthy Blue	Molina	Select Health	WellCare	▶ = *Quality* ▶ = *Timeliness* ▶ = *Access to Care*
						• Examine current methods for updating provider contact information. Develop strategies to improve this process, such as developing additional methods for providers to update their contact information.
Provider Education *42 CFR § 438.414, 42 CFR § 457.1260*						
The MCO formulates and acts within policies and procedures related to initial education of providers	Met	Met	Met	Met	Met	**Strengths:** ▶ The plans have appropriate processes in place for initial and ongoing provider education. The plans have adjusted their processes to ensure provider education processes continue throughout restrictions related to the COVID-19 pandemic. **Weaknesses:** ▶ ATC's Provider Manual did not clearly define all appointment access standards for specialists. ▶ Healthy Blue's Provider Manual did not include information regarding copayments for members in waiver services. ▶ Healthy Blue's Provider Manual did not include medical record documentation standards and did not direct the reader to the standards elsewhere, such as on the website. Healthy Blue was unable to verbalize how providers are educated about medical record documentation standards.
Initial provider education includes: MCO structure and health care programs	Met	Met	Met	Met	Met	
Billing and reimbursement practices	Met	Met	Met	Met	Met	
Member benefits, including covered services, excluded services, and services provided under fee-for-service payment by SCDHHS	Met	Met	Met	Met	Partially Met ↓	
Procedure for referral to a specialist	Met	Met	Met	Met	Met	
Accessibility standards, including 24/7 access	Met	Met	Met	Met	Met	
Recommended standards of care	Met	Met	Met	Met	Met	
Medical record handling, availability, retention and confidentiality	Met	Met	Met	Met	Met	
Provider and member grievance and appeal procedures	Met	Met	Met	Met	Met	
Pharmacy policies and procedures necessary for making informed prescription choices	Met	Met	Met	Met	Met	

Standard	ATC	Healthy Blue	Molina	Select Health	WellCare	▶ = *Quality* ▶ = *Timeliness* ▶ = *Access to Care*
Reassignment of a member to another PCP	Met	Met	Met	Met	Met	▶ WellCare's Member Handbook and Provider Manual had discrepancies in documentation of member benefits. **Recommendations:** • Update processes for provider education to ensure providers are aware of appointment access standards, medical record documentation standards, member benefits, and complete information about copayments.
Medical record documentation requirement.	Met	Met	Met	Met	Met	
The MCO provides ongoing education to providers regarding changes and/or additions to its programs, practices, member benefits, standards, policies and procedures	Met	Met	Met	Met	Met	
Primary and Secondary Preventive Health Guidelines *42 CFR § 438.236, 42 CFR § 457.1233(a)*						
The MCO develops preventive health guidelines for the care of its members that are consistent with national standards and covered benefits and that are periodically reviewed and/or updated	Met	Met	Met	Met	Met	**Strengths:** ▶ Processes are in place for selection, adoption, and ongoing review of Preventive Health Guidelines, including obtaining network provider input. **Weakness:** ▶ WellCare's website did not include the current Preventive Health Guidelines. **Recommendation:** • Ensure websites reflect currently adopted Preventive Health Guidelines.
The MCO communicates the preventive health guidelines and the expectation that they will be followed for MCO members to providers	Met	Met	Met	Met	Partially Met ↓	
The preventive health guidelines include, at a minimum, the following if relevant to member demographics: Well child care at specified intervals, including EPSDTs at State-mandated intervals	Met	Met	Met	Met	Met	
Recommended childhood immunizations	Met	Met	Met	Met	Met	
Pregnancy care	Met	Met	Met	Met	Met	
Adult screening recommendations at specified intervals	Met	Met	Met	Met	Met	

Standard	ATC	Healthy Blue	Molina	Select Health	WellCare	▶ = *Quality* ▶ = *Timeliness* ▶ = *Access to Care*
Elderly screening recommendations at specified intervals	Met	Met	Met	Met	Met	
Recommendations specific to member high-risk groups	Met	Met	Met	Met	Met	
Behavioral Health Services	Met	Met	Met	Met	Met	
Clinical Practice Guidelines for Disease and Chronic Illness Management *42 CFR § 438.236, 42 CFR § 457.1233(a)*						
The MCO develops clinical practice guidelines for disease, chronic illness management, and behavioral health services of its members that are consistent with national or professional standards and covered benefits, are periodically reviewed and/or updated and are developed in conjunction with pertinent network specialists	Met	Met	Met	Met	Met	**Strength:** ▶ Processes are in place for selection, adoption, and ongoing review of Clinical Practice Guidelines, including obtaining network provider input. **Weakness:** ▶ WellCare's website did not include the current Clinical Practice Guidelines. **Recommendation:** • Ensure websites reflect currently adopted Clinical Practice Guidelines.
The MCO communicates the clinical practice guidelines for disease, chronic illness management, and behavioral health services and the expectation that they will be followed for MCO members to providers	Met	Met	Met	Met	Partially Met ↓	
Continuity of Care *42 CFR § 438.208, 42 CFR § 457.1230(c)*						
The MCO monitors continuity and coordination of care between the PCPs and other providers	Met	Met	Met	Met	Met	**Strength:** ▶ Continuity of care between PCPs and other providers is assessed through medical record review and other avenues. Findings are analyzed and used for quality improvement activities.

Standard	ATC	Healthy Blue	Molina	Select Health	WellCare	▶ = *Quality* ▶ = *Timeliness* ▶ = *Access to Care*
Practitioner Medical Records						
The MCO formulates policies and procedures outlining standards for acceptable documentation in the member medical records maintained by primary care physicians	Met	Met	Met	Met	Met	**Strength:** ▶ All health plans have appropriate policies in place outlining provider medical record documentation standards and for assessing provider compliance with those documentation standards.
Standards for acceptable documentation in member medical records are consistent with contract requirements	Met	Met	Met	Met	Met	
The MCO monitors compliance with medical record documentation standards through periodic medical record audit and addresses any deficiencies with the providers	Met	Met	Met	Met	Met	
Accessibility to member medical records by the MCO for the purposes of quality improvement, utilization management, and/or other studies is contractually assured for a period of 5 years following expiration of the contract	Met	Met	Met	Met	Met	

Member Services

42 CFR § 438.56, 42 CFR § 1212, 42 CFR § 438.100, 42 CFR § 438.10, 42 CFR 457.1220, 42 CFR § 457.1207, 42 CFR § 438.3 (j), 42 CFR § 438. 228, 42 CFR § 438, Subpart F, 42 CFR § 457. 1260

CCME's Member Services review focused on areas including member rights and responsibilities, member education and informational materials, Member Satisfaction Surveys, and grievance procedures and files. The health plans have policies and procedures that define and describe Member Services activities, and which provide guidance to staff for performing said activities.

Annual Member Satisfaction Surveys are conducted by each plan using a certified Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey vendor. The data obtained is used to identify quality issues and implement strategies to address them. Survey results are reported to the plans' respective Quality Committees and to network providers as reflected in minutes from committee meetings. Survey sample sizes were adequate for some plans; however, response rates were below the NCQA target of 40% for all plans. CCME recommends that the health plans continue working with survey vendors to increase response rates.

Member Services staff are available per contract requirements via toll-free numbers, which route calls to Interactive Voice Response menus that allow callers to reach staff during the hours of 8:00 a.m. to 6:00 p.m. Eastern Time, Monday through Friday. Nurse Advice Lines are available 24 hours a day. The plans monitor Member Services activities to ensure compliance with performance and response standards.

Member Rights and Responsibilities

42 CFR § 438.100, 42 CFR § 457.1220

The health plans have policies defining member rights and responsibilities, which include the right to be treated with respect, receive information on available treatment options, and freely exercise rights without adverse effects. Members are informed and educated of their rights in various ways, such as Member Handbooks, plan websites, newsletters, and other member educational materials. Health plan staff are trained to access policies or the Member Handbook for a complete list of member rights and responsibilities.

Member Education

42 CFR § 438.56, 42 CFR § 457.1212, 42 CFR § 438.3(j)

Within 14 calendar days of receiving enrollment data from SCDHHS, the health plans provide welcome packets to new members that include plan-specific quick-start and reference guides, information for accessing the Member Handbook and the Provider Directory, an identification card, and member educational materials. In addition to this,

Healthy Blue continues to provide a hard copy of the Member Handbook to new enrollees. Onsite discussions revealed some health plans have added welcome calls to the new-member orientation process.

Member education deficiencies noted during this EQR period included documentation errors in Select Health's policies indicating that new enrollees receive welcome packets within 30 days and a Member ID Card within 15 days, instead of 14 days as required by the *SCDHHS Contract*. Minor issues identified were copayment errors in and omitting services that do not have referral requirements in Member Handbooks (Healthy Blue, Molina), no date on the Member Handbook Change Control log (Healthy Blue), and the annual member newsletter focuses on "quality" related healthcare topics and did not include health/wellness topics and care tips (Molina).

Member Handbooks, various mailing campaigns, telephonic outreach, and website postings are used to encourage members to obtain recommended preventive services. Members are also encouraged to contact Member Services for questions about various health topics, benefit information, and eligible programs. With exception of Healthy Blue, each health plan publishes a member newsletter on their website which provides supplemental information about the health plan, services offered, and special topics of interest. Healthy Blue no longer publishes an annual member newsletter; instead, members receive an Annual Member Notice mailer informing them when required annual information is available for viewing on the website.

Additionally, Member Handbooks provide information on obtaining Advance Directives, requesting disenrollment, and accessing the Fraud and Abuse Hotline. When requested, the health plans will provide Member Handbooks in alternate languages and formats including large font and Braille. Providers are informed about member rights and health plan services in Provider Manuals and provider websites.

As noted in Table 18, WellCare had deficiencies during the 2019 - 2020 EQR related to the revision date for the Member Handbook Change Control Log on the website and no documentation of font sizes for regular and large print member materials. WellCare adequately addressed these issues by updating the website and revising applicable policies for printed member materials.

Table 18: Previous Member Education QIP for WellCare

STANDARD	EQR COMMENTS
III B. Member MCO Program Education	

STANDARD	EQR COMMENTS
1. Members are informed in writing within 14 calendar days from the MCO's receipt of enrollment data of all benefits and MCO information including: 1.22 Additional information as required by the contract and/or federal regulation;	The Member Handbook *Change Control Log* posted on the website does not have the date it was last revised as required by the *SCDHHS Contract, Section 3.13.2.16.* *Quality Improvement Plan: Include revision dates on the Member Handbook Change Control Log as required by SCDHHS Contract Section 3.13.2.16.*
WellCare Response: Revisions have been made to the change control log for the Member Handbook to reflect the revision dates. A sample has been provided and the website has been updated.	
4. Member program education materials are written in a clear and understandable manner and meet contractual requirements.	Policy SC22-MMO-002, Medicaid Post-Enrollment Member Materials Policy and Policy SC22-SM-004, Medicaid Written Marketing Review and Approval Process define requirements for member program materials. WellCare ensures member materials are written no higher than a 6th grade reading level using the Flesch-Kincaid method to determine readability. CCME could not identify the font size used for regular and large print materials as required in the *SCDHHS Contract, Sections 3.15.1.3* and *3.15.2.8.* Onsite discussions revealed WellCare uses 12-point font size for regular print and 18-point font size for large print member materials. *Quality Improvement Plan: Edit policies SC22-MMO-002, Medicaid Post-Enrollment Member Materials Policy and SC22-SM-004, Medicaid Written Marketing Review and Approval Process to include the requirement to use 12-point font size for regular print and 18-point font size for large print member materials as per the SCDHHS Contract, Sections 3.15.1.3* and *3.15.2.8.*
WellCare Response: WellCare updated policies SC22-MMO002 and SC22-SM-004 to include the requirement to use 12 point font size for regular print and 18 point font size for large print member materials as per the SC DHHS Contract.	

Grievances

42 CFR § 438. 228, 42 CFR § 438, Subpart F, 42 CFR § 457. 1260

Grievance requirements and processes are documented in policies, Member Handbooks, Provider Manuals, and websites. The health plans track and analyze grievance data to identify outstanding issues and adverse trends, and results are routinely reported to leadership teams and committees. CCME reviewed randomly selected grievance files to determine the compliance with grievance processes, guidelines, and contractual requirements. Grievance files reflect timely acknowledgement, resolution, and review by appropriate staff.

No deficiencies with grievance documentation or handling were identified during this EQR. However, minor issues were noted, such as not completely instructing members on all information needed when filing written grievances, i.e., Medicaid number and date-of-birth. (Select Health).

With the exception of Select Health, each of the plans had grievance related issues during the 2019 - 2020 EQR. As noted in Tables 19, 20, 21 and 22 the deficiencies identified were related to not including grievance terminology on the website or in the Provider Manual (Healthy Blue), including incorrect filing information in the Member Handbook and Provider Manual (ATC), grievance resolution timeframes (Healthy Blue, WellCare) and not adhering to guidelines in grievance policies and procedures (Molina, WellCare). The plans revised documents and processes to address the deficiencies.

Table 19: Previous Grievances QIP for ATC

STANDARD	EQR COMMENTS
III F. Grievances	
1.2 Procedure for filing and handling a grievance.	The Member Handbook, page 44, and the Provider Manual, page 89, state members or their authorized representatives can request clinically-urgent grievance processing. Onsite discussion confirmed this is incorrect and that expedited grievance processing is strictly an internal process followed when a need for expedited processing is identified. Quality Improvement Plan: Revise the Member Handbook, page 44, and the Provider Manual, page 89, to remove the information indicating members and their authorized representatives may request clinically-urgent grievance processing and resolution.
ATC Response: Updated page 44 of the Provider Manual and page 89 of the Member Handbook, to remove the information indicating Members and their Authorized Representatives may request clinically urgent grievances.	

Table 20: Previous Grievances QIP for Healthy Blue

STANDARD	EQR COMMENTS
III. F. Grievances	
1.1 The definition of a grievance and who may file a grievance;	Information about the definition of a grievance and who may file a grievance is found in Policy SC_GAXX_015, the Provider Manual, and the Member Handbook. Chapter 11 (Member Grievances and Appeals) of the Provider Manual, page 93, states, "For definitions applicable to this section, please refer to Healthy Blue website…" However, the Healthy Blue

STANDARD	EQR COMMENTS
	website does not include a glossary and the information about grievances does not include definitions of terminology. Policy SC_GAXX_015, the Member Handbook, the Provider Manual, and the "Your Grievance and Appeal Rights as a Member of Healthy Blue" document do not address the requirement that written consent is required for a representative to file a grievance on a member's behalf. Discussion during the onsite teleconference confirmed that the health plan does not require written consent for member representation in the grievance process but that they accept verbal consent from the member. ***Quality Improvement Plan: Revise the Healthy Blue website to include definitions of grievance terminology. If the terminology is not added to the website, revise the Provider Manual to include grievance terminology definitions. Revise grievance processes to include the requirement for written member consent for a grievance to be filed on a member's behalf. Update Policy SC_GAXX_015, the Member Handbook, the Provider Manual, and the "Your Grievance and Appeal Rights as a Member of Healthy Blue" document to include this requirement. Refer to the SCDHHS Contract, Section 9.1.1 and 9.1.1.1.2 as well as 42 CFR §438.402 (c) (1) (ii).***
Healthy Blue Response: We are in the process of updating the Healthy Blue Website to include the grievance terminology definitions (website update ticket WEBMBSC-0322-20 Ticket). ETA for completion of website 8/15/2020. Member Handbook (EOC) is being updated to include requirement of written consent to utilize a representative on page 61 (tracked as BSC-MHB-0014-20 and SC MHB Upd). Once reviewed internally, we will submit to SCDHHS for approval. ETA for completion is Q3 2020. Please see DRAFT Member handbook. Currently in the process of updating the Provider Manual to include requirement that member provide written consent for a representative to file a grievance. ETA for completion Q3 2020. Policy SC_GAXX_015 (Member Grievance) was revised to include language regarding member consent for a representative to file grievance on behalf of the member. Policy is being reviewed internally. ETA for completion is Q3 2020. Please see DRAFT policy.	
1.3 Timeliness guidelines for resolution of a grievance;	Grievance resolution and notification timeframes are documented in Policy SC_GAXX_015, the Member Handbook, and the Provider Manual. The "Your Grievance and Appeal Rights as a Member of Healthy Blue" document does not address extensions of grievance resolution timeframes. Neither the Grievance Extension Notification letter (BSC-MEM-0738-18) nor the "Your Grievance and Appeal Rights as a Member of Healthy Blue" document, which is sent as an attachment to grievance letters, informs the member of the right to file a grievance if he or she disagrees with an extension of the grievance resolution timeframe. ***Quality Improvement Plan: Revise the Grievance Extension Notification letter (BSC-MEM-0738-18) or the "Your Grievance and Appeal Rights as a Member of Healthy Blue" document to***

STANDARD	EQR COMMENTS
	include information that a member may file a grievance if he or she disagrees with extension of the grievance resolution timeframe. Revise the "Your Grievance and Appeal Rights as a Member of Healthy Blue" document to include information about extensions of grievance resolution timeframes.
Healthy Blue Response: BSC-MEM-1874-20 SC AG Your Rights Attachment Ltr-Turnaround (Your Grievance and Appeal Rights as a Member of Healthy Blue) has been submitted with requirement for member consent. Is at State review. DRAFT has been attached.	

Table 21: Previous Grievances QIP for Molina

STANDARD	EQR COMMENTS
III F. Grievances	
2. The MCO applies grievance policies and procedures as formulated.	During the previous EQR, CCME noted that grievances referred to the Provider Services department were closed and members were provided resolution prior to receiving resolution from the referred department. For the current EQR, CCME noted this issue continues. CCME's review of grievance files revealed that for grievances referred to Provider Services, there is no documentation of investigation or resolution of the issues about which the member voiced dissatisfaction. The Member Resolution Team informs the member that the Provider Services Department will review their concerns, that corrective action and education will be done if needed, and this will be monitored closely. The resolution provided to the member does not specifically address the member's grievance. Of note, Procedure MHSC-MRT-001, Grievance Disposition Process, Section B (5), states that for grievances related to network providers and not involving potential quality of care issues, resolution will be sent from Provider Services back to the MRT Specialist to complete the grievance process "and notify the member of the grievance resolution." As noted above, this is an uncorrected deficiency from the previous EQR. *Quality Improvement Plan: Revise grievance processes to ensure grievance files include documentation of the investigation of all issues raised by the member, findings of the investigation, and any actions taken to address the specific issues about which the member filed the grievance. Ensure resolution information provided to the member specifically addresses all issues raised in the member's grievance and the actual resolution of those issues.*

STANDARD	EQR COMMENTS
Molina Response: The A&G team will continue to send an email to the Provider Rep team email box attaching the Provider Service template with the appropriate information filled in. The Specialist will wait for the template to be returned to them from the Provider Rep team with the information filled out of what they have done to address the complaint from the member (Column U). The A&G Specialist will fully document in the A&G database the actions the Provider Rep has taken. A phone call will be made to the member to advise of the complete resolution of their complaint addressing all of the member's concern. The phone call conversation will be documented in the A&G database. If the member cannot be reached after three attempts, the current process of sending a resolution letter to the member will be followed. The letter will contain the information of the full resolution of the complaint from the member. The case in the A&G database will not be closed until all of the steps have been followed. An in-service training will be held with the grievance specialists and the Provider Service Reps to review the complete process when initiating contact with provider services. This training will be held by July 15th .	

Table 22: Previous Grievances QIP for WellCare

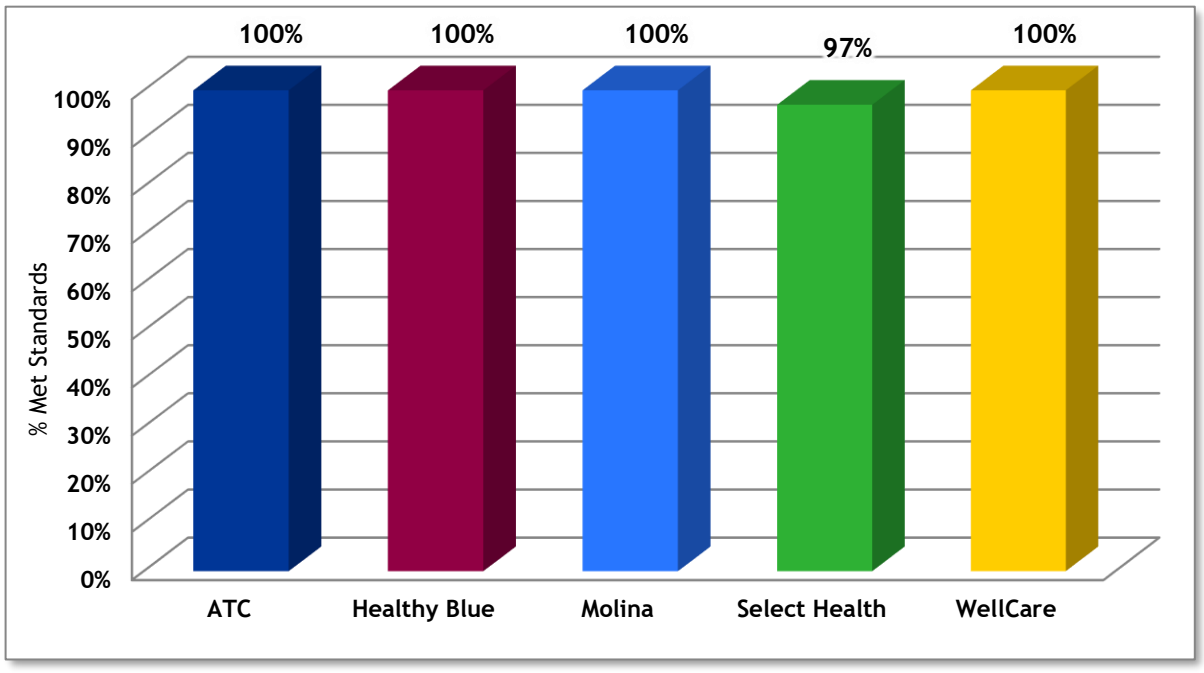
STANDARD	EQR COMMENTS
III F. Grievances	
1. The MCO formulates reasonable policies and procedures for registering and responding to member grievances in a manner consistent with contract requirements, including, but not limited to: 1.3 Timeliness guidelines for resolution of a grievance;	Policy SC22-OP-GR-001, Medicaid Grievance Policy, the Member Handbook, the Provider Manual, and the *Grievance Notice of Extension* letter template do not address the member right to file a grievance if they disagree with a plan-initiated extension of the grievance resolution timeframe. Refer to the *SCDHHS Contract, Section 9.1.6.1.5* through *9.1.6.1.5.2* and *42 CFR § 438.408 (c) (2) (ii)*. *Quality Improvement Plan: Revise the documents listed above to address the requirement that the member must be notified of their right to file a grievance if they disagree with a plan-initiated extension of the grievance resolution timeframe.*
WellCare Response: WellCare corrected the member Grievance letter to be consistent with the Provider Manual and Member Handbook refarding the right to file a grievance if the member disagrees with a plan initiated extension of the grievance resolution timeframe. 3/18/2020-Policy, Member Handbook and Provider Manual uploaded.	
2. The MCO applies grievance policies and procedures as formulated.	CCME's review of 20 grievance files found that the grievance resolutions were timely, and the grievances were properly referred for review as potential quality of care issues. Two of the 20 files were noted with untimely acknowledgement letters. One file contained documentation that "Grievance was resolved within Acknowledgement Letter timeframe. Therefore, one letter sent to member." However, the resolution letter was sent 10 business days after receipt of the

STANDARD	EQR COMMENTS
	grievance. This is outside of the five business-day window to send the acknowledgement letter. One file had an inappropriate resolution to a grievance about the member being billed for physician fees for an emergency room visit. The resolution letter to the member indicated that because this facility is not in the WellCare network, WellCare is limited in its ability to get the facility to stop billing the member. WellCare took no further action to prevent the member from being billed for the emergency services. The *SCDHHS Contract, Sections 4.2.11.1.1, 4.2.11.1.2, and 4.2.11.1.4* states the MCO shall: •cover and pay for emergency services •provide emergency services without prior authorization •promptly pay for emergency services regardless of whether the provider has a contract with the MCO consistent with *42 CFR § 438.114(c)(1)(i)*. *Quality Improvement Plan: Ensure grievance acknowledgement letters are sent within five business-days of receipt of the grievance, as stated in Policy SC22-OP-GR-001. Ensure appropriate actions are taken to address incorrect member billing for emergency services by non-participating providers.*
WellCare Response: WellCare has updated lanhguage with Customer Service to be sure that the process for addressing balance billing is acknowledged immediately. WellCare has a process where the providers are contacted to notify them that balance billing members is not allowed.	

Overall, review of Member Services reflects that each health plan ensures member rights, provides member education and information in various formats, implements a grievance system and operates a call center, according to requirements in the *SCDHHS Contract* and federal regulations.

Figure 8: Member Services provides an overview of the plans' performance in the Member Services section.

Figure 8: Member Services



A comparison of the plans' scores for the standards in the Member Services section is illustrated in *Table 23: Member Services Comparative Data*. The table also indicates strengths, weaknesses, and recommendations related to quality, timeliness, and access to care.

Table 23: Member Services Comparative Data

Standard	ATC	Healthy Blue	Molina	Select Health	WellCare	▶ = *Quality* ▶ = *Timeliness* ▶ = *Access to Care*
Member Rights and Responsibilities *42 CFR § 438.100, 42 CFR § 457.1220*						
The MCO formulates and implements policies guaranteeing each member's rights and responsibilities and processes for informing members of their rights and responsibilities	Met	Met	Met	Met	Met	
All Member rights included	Met	Met	Met	Met	Met	
Member MCO Program Education *42 CFR § 438.56, 42 CFR § 457.1212, 42 CFR § 438.3(j)*						
Members are informed in writing within 14 calendar days from the MCO's receipt of enrollment data of all benefits and MCO information	Met	Met	Met	Partially Met ↓	Met	**Strength:** ▶ One plan's member newsletters are easily accessible on the website and contain information on many health topics, risk factors, and wellness promotion (ATC). **Weaknesses:** ▶ One plan's policies incorrectly state the timeframe for when new enrollees will receive welcome packets. (Select Health). ▶ Two plans did not consistently document correct copayment amounts in Member Handbooks or document services that do not require a PCP referral (Healthy Blue, Molina) and did not include a date in the Member Handbook Change Control log.
Members are notified at least once per year of their right to request a Member Handbook or Provider Directory	Met	Met	Met	Met	Met	
Members are informed in writing of changes in benefits and changes to the provider network	Met	Met	Met	Met	Met	

Standard	ATC	Healthy Blue	Molina	Select Health	WellCare	▶ = *Quality* ▶ = *Timeliness* ▶ = *Access to Care*
Member program education materials are written in a clear and understandable manner and meet contractual requirements	Met	Met	Met	Met	Met	▶ Molina's annual member newsletter focused on "quality" related healthcare topics and did not include health/wellness topics and care tips (Molina). **Recommendations:** • Ensure policies include correct timeframes for new enrollees to receive orientation packets and correctly document that Member Handbooks are not included in welcome packets. • Ensure Member Handbooks include correct copayment amounts and information on services that do not require referrals. • Ensure that the Member Handbook Change Control Log includes dates when changes are made. • Ensure health/wellness topics and care tips are included in the Member Newsletter, other member material or on the website.
The MCO maintains, and informs members how to access, a toll-free vehicle for 24-hour member access to coverage information from the MCO	Met	Met	Met	Met	Met	
Member Enrollment and Disenrollment *42 CFR § 438.56*						
The MCO enables each member to choose a PCP upon enrollment and provides assistance if needed	Met	Met	Met	Met	Met	
MCO-initiated member disenrollment requests are compliant with contractual requirements	Met	Met	Met	Met	Met	

Standard	ATC	Healthy Blue	Molina	Select Health	WellCare	▶ = *Quality* ▶ = *Timeliness* ▶ = *Access to Care*
Preventive Health and Chronic Disease Management Education						
The MCO informs members of available preventive health and disease management services and encourages members to utilize these services	Met	Met	Met	Met	Met	
The MCO tracks children eligible for recommended EPSDT services/immunizations and encourages members to utilize these benefits	Met	Met	Met	Met	Met	
The MCO provides education to members regarding health risk factors and wellness promotion	Met	Met	Met	Met	Met	
The MCO identifies pregnant members; provides educational information related to pregnancy, prepared childbirth, and parenting; and tracks the participation of pregnant members in recommended care	Met	Met	Met	Met	Met	
Member Satisfaction Survey						
The MCO conducts a formal annual assessment of member satisfaction with MCO benefits and services. This assessment includes, but is not limited to	Met	Met	Met	Met	Met	**Weakness:** ▶ Member satisfaction survey response rates continue to fall below the NCQA target response rate of 40% for all health plans. **Recommendation:** • Continue working with member satisfaction survey vendors to identify methods that can improve responses to member Satisfaction Surveys.
Statistically sound methodology, including probability sampling to ensure it is representative of the total membership	Met	Met	Met	Met	Met	

Standard	ATC	Healthy Blue	Molina	Select Health	WellCare	▶ = *Quality* ▶ = *Timeliness* ▶ = *Access to Care*
The availability and accessibility of health care practitioners and services	Met	Met	Met	Met	Met	
The quality of health care received from MCO providers	Met	Met	Met	Met	Met	
The scope of benefits and services	Met	Met	Met	Met	Met	
Claim processing procedures	Met	Met	Met	Met	Met	
Adverse MCO claim decisions	Met	Met	Met	Met	Met	
The MCO analyzes data obtained from the member satisfaction survey to identify quality issues	Met	Met	Met	Met	Met	
The MCO implements significant measures to address quality issues identified through the member satisfaction survey	Met	Met	Met	Met	Met	
The MCO reports the results of the member satisfaction survey to providers	Met	Met	Met	Met	Met	
The MCO reports results of the member satisfaction survey and the impact of measures taken to address identified quality issues to the Quality Improvement Committee	Met	Met	Met	Met	Met	
Grievances *42 CFR § 438. 228, 42 CFR § 438, Subpart F, 42 CFR § 457. 1260*						
The MCO formulates reasonable policies and procedures for registering and responding to member grievances in a manner consistent with contract requirements, including, but not limited to	Met	Met	Met	Met	Met	**Strength:** ▶ For all health plans, grievance notices were timely and provided clear and concise

Standard	ATC	Healthy Blue	Molina	Select Health	WellCare	▶ = *Quality* ▶ = *Timeliness* ▶ = *Access to Care*
The definition of a grievance and who may file a grievance	Met	Met ↑	Met	Met	Met	information addressing the member's grievance and any follow-up that occurred. ▶ Grievance files reflect timely acknowledgement, resolution, and review by appropriate staff. **Weakness:** ▶ Members are not given full instructions about information needed when filing written grievances, i.e., Medicaid number and date-of-birth. (Select Health). **Recommendation:** • Ensure grievance instruction includes all necessary information, such as the member's Medicaid number and date-of-birth, for filing written grievances.
Procedures for filing and handling a grievance	Met ↑	Met	Met	Met	Met	
Timeliness guidelines for resolution of a grievance	Met	Met ↑	Met	Met	Met	
Review of grievances related to clinical issues or denial of expedited appeal resolution by a Medical Director or a physician designee	Met	Met	Met	Met	Met	
Maintenance and retention of a grievance log and grievance records for the period specified in the contract	Met	Met	Met	Met	Met	
The MCO applies grievance policies and procedures as formulated	Met	Met	Met ↑	Met	Met	
Grievances are tallied, categorized, analyzed for patterns and potential quality improvement opportunities, and reported to the Quality Improvement Committee	Met	Met	Met	Met	Met	
Grievances are managed in accordance with the MCO confidentiality policies and procedures	Met	Met	Met	Met	Met	

Quality Improvement

Medicaid Managed Care Organizations are required to have an ongoing comprehensive quality assessment and performance improvement program for the services furnished to members. The Quality Improvement (QI) section of the EQR of the health plans in SC included review of the programs' structures, work plans, program evaluations, performance measure validation, and performance improvement project validation.

The health plans' program descriptions explain the programs' structure, accountabilities, scope, goals, and needed resources. The program descriptions are reviewed and updated at least annually.

Each health plan has an annual plan of QI activities in place which includes areas to be studied, follow-up of previous projects where appropriate, timeframes for implementation and completion, and the person(s) responsible for the project(s).

During the previous EQR, several errors related to the goals and benchmarks being measured were noted in Molina's the 2020 work plan. *Table 24: Previous Annual QI Work Plan QIP for Molina* provides a summary of the errors and Molina's response for correcting those errors.

Table 24: Previous Annual QI Work Plan QIP for Molina

Standard	EQR Comments
IV A. The Quality Improvement (QI) Program	
3. An annual plan of QI activities is in place which includes areas to be studied, follow up of previous projects where appropriate, timeframe for implementation and completion, and the person(s) responsible for the project(s).	Annually, Molina develops a QI Work Plan to guide and monitor activities for the year. The health plan provided the 2019 and 2020 QI Work Plans. The 2020 Work Plan was marked as a draft. There were several issues identified in the 2020 work plan regarding the benchmark and goals listed. Those included: • Policy and Procedure PC-011, Provider Contracting, lists the standards for PCP to member ratios and the distance and time access requirements. The following goals were incorrect in the work plan: ○ The ratio of PCPs to members being measured does not include FQHCs and RHCs (page 13). ○ The ratio of OB/GYNs is incorrectly listed as 1:5,000 members (page 14). ○ The goal listed for high impact specialists to member is 90% instead of the ratio of specialist to member (page 14). ○ For PCPs, only distance is measured; the access standard for time is not measured (page 16). ○ For high impact, high volume specialists, the distance goal (30 miles) is incorrect and time is not included. Also, OB/GYNs are not included in the measurement (page 17).

Standard	EQR Comments
	○ The distance goal (30 miles) is incorrect for behavioral health providers and time is not included (page 18). • In Policy MHSC-PS-005, Provider Availability Standards, and the Provider Manual, the following issues were noted in the QI Work Plan related to appointment access: ○ Routine appointments are listed as within 4 weeks in the policy and in the Provider Manual. The QI Work Plan lists the goal as within 6 weeks (page 20). ○ Follow-up routine appointment for behavioral health providers is listed as "X" in the QI Work Plan (page 23). ○ Routine appointment for specialty providers is listed as 30 calendar days in the QI Work Plan (page 26). The policy lists this standard as within 12 weeks. • Policy MHSC-MS-01, Contact Center Performance, lists the performance standards for the contact center. ○ Service level goal is listed as 85% within 30 seconds and the average speed to answer (ASA) goal is listed as 30 seconds. The policy does not mention service level and lists the ASA goal as 80%. (page 20 and 52). ○ The ASA goal is listed as 95% within 30 seconds on page 23. The policy lists the goal as 80%. • The medical record monitoring discussed on page 35 and 39 of the QI Work Plan lists the goal as 80%. The medical record monitoring tool and procedure MHSC QI 120.000, Assessing for Standards of Medical Record Documentation, lists this goal as 90%. *Quality Improvement Plan: Correct the errors identified in the 2020 QI Work Plan.*
Molina Response: The 2020 QI Work Plan is in the draft format and is a working/living document that is edited throughout the year depending on opportunities and issues identified. Based on the recommendations provided, Molina SC made revisions to the draft work plan. The revision details and comments are listed below corresponding to the recommendations. The updates are yellow-highlighted in 2020 Medicaid QI Work Plan. 1. Workplan Revisions related to Policy and Procedure PC-011, Availability of Healthcare 1.1. PC-011 Availability of Health Care was updated to remove FQHCs and RHCs ratios. 1.2. Slide 14 is updated from 1:5000 to 1:2500. (update provided on 4/23/2020) 1.3. Slide 14 is updated to reflect ratio rather than percentage for high impact specialists. (update provided on 4/23/2020) 1.4. Slide 16 is updated to include both time and distance for PCPs. 1.5. Slide 17 is updated from 30 miles to 50 miles.(update provided on 4/23/2020) The time measurement goal and OB/GYN are added. 1.6. Slide 18 is updated from 30 miles to 50 miles.(update provided on 4/23/2020) The time measurement goal is added. 2. Workplan Revisions related to Provider Availiability Standards 2.1. Slide 20 is updated to reflect 4 weeks. (update provided on 4/23/2020) 2.2. Slide 23 is updated from "X" to 30. (update provided on 4/23/2020) 2.3. Slide 26 is updated from 30 calendar days to within 12 weeks. 3. Work Plan Reivsions related to Policy MHSC-MS-01 Contact Center Performance 3.1. Slide 20 and 52 are updated from 85% to 80%. (update provided on 4/23/2020) 3.2. Slide 23 is updated from 95% to 80%. (update provided on 4/23/2020) 4. Slide 35 and 39 are updated from 80% to 90%.	

Standard	EQR Comments
7/20/20 - PC-011 Availability of Health Care was updated to include FQHCs and RHCs ratios and measurements of time and distance. 2020 Medicaid QI Work Plan has been updated to include FQHC and RHC. Please see revisions below: Slide 13 is updated to include FQHC and RHC for the ratios. Slide 16 is updated to include FQHC and RHC for the time and distance measurement.	

Molina corrected those errors; however, the dates in the column labeled "Timeline" were not updated. Molina indicated the work plan was in draft form and the timeline dates would be updated.

A committee was established for each plan charged with oversight of the QI programs. The committees review data received from the QI activities to ensure performance meets standards and make recommendations as needed. Membership for the quality committees included the health plan's senior leadership, department directors and managers, and other plan staff. Network providers of varying specialties are included as voting members.

Each plan evaluates the overall effectiveness of the QI Program and reports this evaluation to the Board of Directors and to various Quality Improvement Committees. It was noted during the previous EQR for Molina that the 2018 QI Program Evaluation did not include all the quality improvement activities. Molina addressed those missing activities in their Quality Improvement Plan submitted following last year's EQR. *Table 25: Previous Annual Evaluation of the QI Program QIP for Molina* provides a summary of the issues and Molina's response. The review of Molina's 2019 program evaluation found that Molina included summaries and analyses of all activities. Section 14, Areas of Focus/Recommendations for Next Year, was not included. However, this was provided during the onsite.

Table 25: Previous Annual Evaluation of the QI Program QIP for Molina

Standard	EQR Comments
IV F. Annual Evaluation of the Quality Improvement Program	
1. A written summary and assessment of the effectiveness of the QI program for the year is prepared annually.	According to Molina's 2019 QI Program Description, Molina conducts a formal evaluation of the QI program annually. The evaluation includes all quality activities with a description of limitations, barriers to improvements, recommendations, and the overall effectiveness of the program. Molina provided the 2018 Molina of South Carolina QI Program Evaluation/Executive Summary. This summary did not include all quality improvement activities. Practitioner Availability and Accessibility of Services, patient safety

Standard	EQR Comments
	initiatives, medical record review activities, delegation monitoring, and performance improvement project results were not included. *Quality Improvement Plan: A complete evaluation of the QI Program should be conducted annually to include all QI activity results, barriers encountered, and recommendations for improvements.*
Molina Response: After EQR review and comments from the first day, Quality noted the document submitted was missing components. Please see 2018 Annual Eval Executive Summary with bookmarking for barriers and improvement opportunities.(MHSC 2018 Executive Summary_Final_v3") Please see 2018 QI Annual Evaluation Word document which contains patient safety activities (page 5 from "2018 QI Annual Evaluation - Executive Summary_ Final-v3"). 2018 full report of Provider Access and Availibility, Standard Medical Record Review Audit analysis, delegation monitoring, and Performance Improvement Project results were provided and reviewed during the onsite review. 7/20/20 - Please see the draft outline for the Quality Improvement Program Evaluation to ensure inclusion of quality improvement activities' goals, barriers, and interventions.	

Performance Measure Validation

Health plans are required to report plan performance using HEDIS® measures applicable to the Medicaid population. To evaluate the accuracy of the PMs reported, CCME uses the CMS Protocol, *Validation of Performance Measures*. This validation protocol balances the subjective and objective parts of the review, supports a review that is fair to the plans, and provides the State with information about how each plan is operating.

All plans are using a HEDIS® certified vendor or software to collect and calculate the measures, and all were found "Fully Compliant." Plan rates for the most recent review year are reported in *Table 26: HEDIS® Performance Measure Data for HEDIS 2020*. The statewide average is calculated as the average of the plan rates and shown in the last column in the table. Rates highlighted in green showed a substantial improvement of more than 10 percent year over year. The rates highlighted in red indicates a substantial decrease in the rate of more than 10 percent.

Table 26: HEDIS® Performance Measure Data for HEDIS 2020

Measure/Data Element	ATC	Healthy Blue	Molina	Select Health	WellCare	Statewide Average
Effectiveness of Care: Prevention and Screening						
Adult BMI Assessment (aba)	87.35%	87.35%	93.08%	87.76%	77.91%	86.69%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (wcc)						
BMI Percentile	87.59%	80.29%	78.52%	79.90%	82.48%	81.76%

Measure/Data Element	ATC	Healthy Blue	Molina	Select Health	WellCare	Statewide Average
Counseling for Nutrition	72.26%	67.15%	66.17%	64.07%	63.75%	66.68%
Counseling for Physical Activity	67.40%	62.53%	61.48%	59.30%	59.12%	61.97%
Childhood Immunization Status (cis)						
DTaP	72.26%	75.91%	74.94%	77.62%	70.32%	74.21%
IPV	90.75%	88.08%	84.18%	92.46%	83.45%	87.78%
MMR	87.59%	88.08%	88.08%	88.56%	85.16%	87.49%
HiB	82.48%	83.45%	83.70%	85.40%	79.56%	82.92%
Hepatitis B	90.27%	89.29%	84.91%	91.97%	80.54%	87.40%
VZV	86.62%	87.83%	87.59%	88.32%	84.91%	87.05%
Pneumococcal Conjugate	78.35%	78.10%	77.13%	82.97%	70.56%	77.42%
Hepatitis A	85.16%	83.70%	82.97%	84.43%	82.97%	83.85%
Rotavirus	73.97%	71.29%	70.07%	78.59%	67.15%	72.21%
Influenza	39.90%	41.85%	37.96%	38.69%	36.25%	38.93%
Combination #2	67.88%	71.53%	70.32%	74.21%	65.69%	69.93%
Combination #3	65.94%	69.59%	68.86%	72.51%	62.29%	67.84%
Combination #4	64.96%	67.88%	66.67%	70.56%	60.83%	66.18%
Combination #5	57.18%	60.10%	58.64%	63.50%	53.04%	58.49%
Combination #6	32.85%	36.50%	32.60%	34.31%	28.71%	32.99%
Combination #7	56.69%	59.12%	57.18%	62.53%	51.82%	57.47%
Combination #8	32.60%	36.25%	32.60%	34.31%	28.71%	32.89%
Combination #9	28.95%	32.60%	28.71%	31.39%	25.06%	29.34%
Combination #10	28.71%	32.36%	28.71%	31.39%	25.06%	29.25%
Immunizations for Adolescents (ima)						
Meningococcal	72.02%	72.02%	77.13%	76.40%	68.61%	73.24%
Tdap/Td	82.00%	83.21%	87.10%	89.54%	78.83%	84.14%
Combination #1	71.05%	71.29%	76.40%	75.43%	67.88%	72.41%
Combination #2	31.39%	28.71%	31.87%	33.33%	27.25%	30.51%
Human Papillomavirus Vaccine for Female Adolescents (hpv)	32.36%	29.68%	32.12%	34.06%	27.98%	31.24%
Lead Screening in Children (lsc)	68.35%	72.99%	69.34%	76.32%	69.88%	71.38%
Breast Cancer Screening (bcs)	62.64%	53.28%	57.26%	60.49%	57.04%	58.14%
Cervical Cancer Screening (ccs)	65.94%	57.61%	64.72%	68.71%	57.42%	62.88%
Chlamydia Screening in Women (chl)						
16-20 Years	59.55%	53.38%	57.87%	58.16%	61.25%	58.04%
21-24 Years	66.48%	61.82%	68.95%	66.09%	70.03%	66.67%
Total	61.47%	56.20%	60.82%	59.98%	63.46%	60.39%
Effectiveness of Care: Respiratory Conditions						
Appropriate Testing for Children with Pharyngitis (cwp)						

Measure/Data Element	ATC	Healthy Blue	Molina	Select Health	WellCare	Statewide Average
3-17 years	83.27%	86.49%	86.02%	86.21%	86.10%	85.62%
18-64	71.60%	74.28%	72.71%	75.13%	73.83%	73.51%
65+	70.59%	NA*	NA	NA	NR*	70.59%
Total	81.09%	83.94%	83.23%	84.49%	84.02%	83.35%
Use of Spirometry Testing in the Assessment and Diagnosis of COPD (spr)	26.65%	25.79%	31.62%	32.96%	23.12%	28.03%
Pharmacotherapy Management of COPD Exacerbation (pce)						
Systemic Corticosteroid	63.22%	58.53%	64.12%	64.04%	63.02%	62.59%
Bronchodilator	78.11%	74.68%	76.91%	83.87%	71.35%	76.98%
Medication Management for People With Asthma (mma)						
5-11 Years - Medication Compliance 50%	51.10%	59.20%	59.15%	63.62%	54.05%	57.42%
5-11 Years - Medication Compliance 75%	24.28%	29.22%	31.62%	35.72%	26.76%	29.52%
12-18 Years - Medication Compliance 50%	50.64%	52.76%	58.05%	59.47%	49.79%	54.14%
12-18 Years - Medication Compliance 75%	27.02%	29.14%	29.03%	33.77%	25.32%	28.86%
19-50 Years - Medication Compliance 50%	60.50%	58.38%	63.13%	58.26%	45.54%	57.16%
19-50 Years - Medication Compliance 75%	33.00%	30.27%	33.75%	37.76%	24.75%	31.91%
51-64 Years - Medication Compliance 50%	75.86%	80.85%	67.27%	70.71%	61.54%*	73.67%
51-64 Years - Medication Compliance 75%	44.83%	55.32%	47.27%	50.71%	46.15%*	49.53%
Total - Medication Compliance 50%	53.44%	58.06%	59.56%	61.56%	51.77%	56.88%
Total - Medication Compliance 75%	27.48%	30.51%	31.54%	35.50%	26.70%	30.35%
Asthma Medication Ratio (amr)						
5-11 Years	79.72%	80.43%	77.35%	74.10%	71.28%	76.58%
12-18 Years	71.72%	72.65%	69.80%	64.19%	56.93%	67.06%
19-50 Years	60.16%	49.21%	53.33%	56.11%	39.73%	51.71%
51-64 Years	61.84%	55.22%	47.87%	47.15%	38.78%	50.17%
Total	72.68%	70.40%	68.94%	67.28%	59.49%	67.76%
Effectiveness of Care: Cardiovascular Conditions						
Controlling High Blood Pressure (cbp)	50.85%	52.80%	57.18%	60.10%	39.66%	52.12%
Persistence of Beta-Blocker Treatment After a Heart Attack (pbh)	79.37%	NA*	64.29%	77.66%	73.68%*	73.77%
Statin Therapy for Patients With Cardiovascular Disease (spc)						
Received Statin Therapy - 21-75 years (Male)	79.47%	78.41%	73.57%	78.25%	75.92%	77.12%

Measure/Data Element	ATC	Healthy Blue	Molina	Select Health	WellCare	Statewide Average
Statin Adherence 80% - 21-75 years (Male)	59.41%	62.36%	47.31%	60.70%	51.03%	56.16%
Received Statin Therapy - 40-75 years (Female)	80.46%	75.00%	73.20%	76.90%	78.29%	76.77%
Statin Adherence 80% - 40-75 years (Female)	63.97%	55.56%	48.59%	54.49%	44.55%	53.43%
Received Statin Therapy - Total	79.94%	76.85%	73.40%	77.56%	76.88%	76.93%
Statin Adherence 80% - Total	61.58%	59.32%	47.90%	57.55%	48.37%	54.94%
Effectiveness of Care: Diabetes						
Comprehensive Diabetes Care (cdc)						
Hemoglobin A1c (HbA1c) Testing	91.06%	86.86%	89.77%	89.35%	88.77%	89.16%
HbA1c Poor Control (>9.0%)	41.42%	46.47%	47.49%	46.03%	41.85%	44.65%
HbA1c Control (<8.0%)	49.27%	44.04%	44.19%	43.50%	48.31%	45.86%
HbA1c Control (<7.0%)	BR	NR	NR	29.20%	40.63%	34.92%
Eye Exam (Retinal) Performed	57.85%	41.12%	61.87%	55.42%	52.62%	53.78%
Medical Attention for Nephropathy	91.42%	89.78%	93.41%	91.16%	91.23%	91.40%
Blood Pressure Control (<140/90 mm Hg)	55.66%	56.69%	55.46%	60.29%	55.38%	56.70%
Statin Therapy for Patients With Diabetes (spd)						
Received Statin Therapy	68.25%	63.99%	64.37%	60.72%	63.48%	64.16%
Statin Adherence 80%	60.30%	52.38%	47.06%	53.12%	47.14%	52.00%
Effectiveness of Care: Behavioral Health						
Antidepressant Medication Management (amm)						
Effective Acute Phase Treatment	43.12%	50.38%	44.36%	45.52%	40.92%	44.86%
Effective Continuation Phase Treatment	26.38%	31.71%	29.13%	29.82%	27.58%	28.92%
Follow-Up Care for Children Prescribed ADHD Medication (add)						
Initiation Phase	44.08%	42.08%	58.76%	44.38%	38.18%	45.50%
Continuation and Maintenance (C&M) Phase	59.46%	56.32%	70.05%	56.88%	52.82%	59.11%
Follow-Up After Hospitalization for Mental Illness (fuh)						
6-17 years - 30-Day Follow-Up	70.48%	66.22%	75.86%	74.62%	68.15%	71.07%
6-17 years - 7-Day Follow-Up	45.18%	40.09%	50.19%	48.99%	43.70%	45.63%
18-64 years - 30-Day Follow-Up	47.86%	50.35%	54.28%	57.21%	56.36%	53.21%
18-64 years - 7-Day Follow-Up	27.78%	27.02%	28.62%	33.41%	31.79%	29.72%
Total - 30-Day Follow-Up	53.48%	55.73%	61.33%	67.03%	59.67%	59.45%
Total - 7-Day Follow-Up	31.67%	31.45%	35.67%	42.20%	35.14%	35.23%
Follow-Up After Emergency Department Visit for Mental Illness (fum)						
6-17 years - 30-Day Follow-Up	68.09%	68.38%	71.52%	73.95%	68.42%	70.07%

Measure/Data Element	ATC	Healthy Blue	Molina	Select Health	WellCare	Statewide Average
6-17 years - 7-Day Follow-Up	44.07%	48.43%	52.12%	56.91%	47.37%	49.78%
18-64 years - 30-Day Follow-Up	47.20%	47.60%	52.89%	51.31%	46.34%	49.07%
18-64 years - 7-Day Follow-Up	31.90%	31.58%	36.89%	36.27%	34.76%	34.28%
Total - 30-Day Follow-Up	55.47%	56.85%	60.77%	65.76%	55.83%	58.94%
Total - 7-Day Follow-Up	36.78%	39.09%	43.33%	49.45%	40.17%	41.76%
Follow-Up After High-Intensity Care for Substance Use Disorder (fui)						
13-17 years - 30-Day Follow-Up	NA	NA	42.86%	54.17%	50.00%*	48.52%
13-17 years - 7-Day Follow-Up	NA	NA	28.57%	29.17%	0.00%*	28.87%
18-64 years - 30-Day Follow-Up	39.65%	39.59%	53.81%	39.41%	31.47%	40.79%
18-64 years - 7-Day Follow-Up	28.63%	30.96%	43.65%	28.82%	21.68%	30.75%
Total - 30-Day Follow-Up	40.71%	39.32%	53.43%	40.38%	32.21%	41.21%
Total - 7-Day Follow-Up	29.25%	31.07%	43.14%	28.85%	20.81%	30.62%
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence (fua)						
13-17 years - 30-Day Follow-Up	NA	NA	NA	11.00%	8.33%*	11.00%
13-17 years - 7-Day Follow-Up	NA	NA	NA	3.00%	8.33%*	3.00%
18-64 years - 30-Day Follow-Up	11.91%	39.59%	14.25%	16.59%	17.42%	19.95%
18-64 years - 7-Day Follow-Up	7.19%	30.96%	9.90%	12.26%	12.90%	14.64%
30-Day Follow-Up: Total	11.81%	39.32%	14.61%	15.86%	17.08%	19.74%
7-Day Follow-Up: Total	7.09%	31.07%	10.05%	11.05%	12.73%	14.40%
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medication (ssd)	76.71%	73.43%	78.83%	80.26%	72.83%	76.41%
Diabetes Monitoring for People With Diabetes and Schizophrenia (smd)	72.88%	65.36%	72.09%	71.11%	64.86%	69.26%
Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia (smc)	75.00%	NA*	NA*	83.33%*	88.89%*	75.00%
Pharmacotherapy for Opioid Use Disorder (pod)						
16-64 years	48.69%	29.02%	32.26%	25.35%	49.15%	36.89%
65+ years	NA	NA	NA*	0.00%*	50.00%*	NA
Total	48.38%	29.02%	32.26%	25.30%	49.16%	36.82%
Adherence to Antipsychotic Medications for Individuals With Schizophrenia (saa)	64.11%	62.24%	72.47%	66.43%	67.11%	66.47%
Metabolic Monitoring for Children and Adolescents on Antipsychotics (apm)						
Blood glucose testing - 1-11 Years	41.51%	44.83%	33.03%	50.30%	41.82%	42.30%
Cholesterol Testing - 1-11 Years	28.30%	25.29%	25.69%	39.24%	23.64%	28.43%

Measure/Data Element	ATC	Healthy Blue	Molina	Select Health	WellCare	Statewide Average
Blood glucose and Cholesterol Testing - 1-11 Years	25.47%	25.29%	22.02%	36.52%	21.82%	26.22%
Blood glucose testing - 12-17 Years	51.85%	55.70%	54.80%	63.00%	66.36%	58.34%
Cholesterol Testing - 12-17 Years	30.16%	32.91%	31.32%	44.27%	37.27%	35.19%
Blood glucose and Cholesterol Testing - 12-17 Years	24.87%	29.11%	28.83%	42.21%	37.27%	32.46%
Blood glucose testing - Total	48.14%	51.84%	48.72%	58.65%	58.18%	53.11%
Cholesterol Testing - Total	29.49%	30.20%	29.74%	42.55%	32.73%	32.94%
Blood glucose and Cholesterol Testing - Total	25.08%	27.76%	26.92%	40.26%	32.12%	30.43%
Effectiveness of Care: Overuse/Appropriateness						
Non-Recommended Cervical Cancer Screening in Adolescent Females (ncs)	1.90%	0.37%	0.93%	0.85%	0.91%	0.99%
Appropriate Treatment for Children With URI (uri)						
3months-17 Years	88.19%	87.79%	88.10%	86.99%	87.90%	87.79%
18-64 Years	67.54%	67.58%	66.01%	69.27%	68.48%	67.78%
65+ Years	46.63%	NA*	NA*	NA*	NA*	46.63%
Total	85.17%	85.12%	85.12%	85.14%	85.53%	85.22%
Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis (aab)						
3 months-17 Years	57.45%	57.85%	54.83%	52.31%	54.75%	55.44%
18-64 Years	34.23%	31.98%	30.41%	28.86%	28.37%	30.77%
65+ Years	24.16%	NA*	NA*	NA	NA*	24.16%
Total	49.22%	49.28%	45.49%	45.81%	46.01%	47.16%
Use of Imaging Studies for Low Back Pain (lbp)	69.69%	69.62%	70.69%	74.62%	70.52%	71.03%
Use of Opioids at High Dosage (hdo)	2.71%	5.05%	2.25%	4.55%	5.24%	3.96%
Use of Opioids From Multiple Providers (uop)						
Multiple Prescribers	17.96%	22.84%	24.11%	20.58%	24.04%	21.91%
Multiple Pharmacies	5.55%	3.89%	6.08%	5.96%	5.48%	5.39%
Multiple Prescribers and Multiple Pharmacies	2.33%	2.46%	3.02%	3.09%	3.40%	2.86%
Risk of Continued Opioid Use (cou)						
18-64 years - >=15 Days covered	4.02%	2.74%	4.68%	2.04%	4.51%	3.60%
18-64 years - >=31 Days covered	2.18%	2.26%	3.00%	1.02%	3.68%	2.43%
*65+ years - >=15 Days covered**	16.12%	NA	NA*	NA*	NA*	16.12%
*65+ years - >=31 Days covered**	7.21%	NA	NA*	NA*	NA*	7.21%
Total - >=15 Days covered	5.39%	2.74%	4.68%	2.04%	4.51%	3.87%
Total - >=31 Days covered	2.75%	2.26%	3.00%	1.02%	3.68%	2.54%

Measure/Data Element	ATC	Healthy Blue	Molina	Select Health	WellCare	Statewide Average
Access/Availability of Care						
Adults' Access to Preventive/Ambulatory Health Services (aap)						
20-44 Years	76.92%	76.21%	79.59%	79.52%	73.33%	77.11%
45-64 Years	85.35%	85.13%	89.09%	88.53%	84.43%	86.51%
*65+ Years**	91.79%	NA*	NA*	100.00%*	NA*	91.79%
Total	81.93%	78.73%	82.75%	81.59%	77.10%	80.42%
Children and Adolescents' Access to Primary Care Practitioners (cap)						
12-24 Months	96.92%	96.88%	96.71%	97.30%	95.94%	96.75%
25 Months - 6 Years	85.93%	86.78%	86.86%	89.92%	85.48%	86.99%
7-11 Years	88.57%	88.53%	90.20%	91.95%	86.80%	89.21%
12-19 Years	86.82%	86.15%	90.05%	90.98%	85.80%	87.96%
Initiation and Engagement of AOD Dependence Treatment (iet)						
*Alcohol abuse or dependence: Initiation of AOD Treatment: 13-17 Years**	NA	NA*	NA*	25.53%	36.84%	31.19%
*Alcohol abuse or dependence: Engagement of AOD Treatment: 13-17 Years**	NA	NA*	NA*	5.32%	21.05%	13.19%
*Opioid abuse or dependence: Initiation of AOD Treatment: 13-17 Years**	NA	NA*	NA*	42.11%*	50.00%	50.00%
*Opioid abuse or dependence: Engagement of AOD Treatment: 13-17 Years**	NA	NA*	NA*	15.79%	0.00%	7.90%
Other drug abuse or dependence: Initiation of AOD Treatment: 13-17 Years	32.64%	36.84%	38.73%	32.12%	36.54%	35.37%
Other drug abuse or dependence: Engagement of AOD Treatment: 13-17 Years	15.28%	14.29%	21.83%	16.13%	24.04%	18.31%
Initiation of AOD Treatment: 13-17 Years	33.33%	36.99%	38.26%	31.06%	35.09%	34.95%
Engagement of AOD Treatment: 13-17 Years	15.38%	13.01%	20.81%	15.26%	22.81%	17.45%
Alcohol abuse or dependence: Initiation of AOD Treatment: 18+ Years	40.55%	38.50%	41.92%	38.72%	40.24%	39.99%
Alcohol abuse or dependence: Engagement of AOD Treatment: 18+ Years	7.21%	8.72%	8.08%	8.92%	4.97%	7.58%
Opioid abuse or dependence: Initiation of AOD Treatment: 18+ Years	43.93%	52.14%	57.74%	54.30%	44.48%	50.52%
Opioid abuse or dependence: Engagement of AOD Treatment: 18+ Years	19.08%	24.18%	27.30%	29.27%	20.00%	23.97%

Measure/Data Element	ATC	Healthy Blue	Molina	Select Health	WellCare	Statewide Average
Other drug abuse or dependence: Initiation of AOD Treatment: 18+ Years	38.79%	39.64%	39.55%	36.66%	38.77%	38.68%
Other drug abuse or dependence: Engagement of AOD Treatment: 18+ Years	7.84%	10.16%	8.59%	9.94%	8.36%	8.98%
Initiation of AOD Treatment: 18+ Years	39.61%	40.78%	42.89%	40.16%	39.24%	40.54%
Engagement of AOD Treatment: 18+ Years	9.85%	11.87%	11.05%	13.12%	8.64%	10.91%
Alcohol abuse or dependence: Initiation of AOD Treatment: Total	40.45%	38.52%	41.80%	37.75%	40.13%	39.73%
Alcohol abuse or dependence: Engagement of AOD Treatment: Total	7.47%	8.58%	8.02%	8.66%	5.47%	7.64%
Opioid abuse or dependence: Initiation of AOD Treatment: Total	43.95%	52.24%	57.44%	54.01%	44.52%	50.43%
Opioid abuse or dependence: Engagement of AOD Treatment: Total	19.19%	24.13%	27.15%	28.95%	19.86%	23.86%
Other drug abuse or dependence: Initiation of AOD Treatment: Total	38.11%	39.31%	39.46%	35.56%	38.49%	38.19%
Other drug abuse or dependence: Engagement of AOD Treatment: Total	8.67%	10.65%	10.04%	11.44%	10.31%	10.22%
Initiation of AOD Treatment: Total	39.21%	40.49%	42.57%	38.61%	38.93%	39.96%
Engagement of AOD Treatment: Total	10.20%	11.95%	11.72%	13.48%	9.70%	11.41%
Prenatal and Postpartum Care (ppc)						
Timeliness of Prenatal Care	93.67%	90.98%	99.76%	88.19%	93.19%	93.16%
Postpartum Care	78.83%	70.22%	83.21%	70.83%	74.94%	75.61%
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (app)						
*1-11 Years**	54.55%	50.00%	60.00%	65.57%	52.94%	56.61%
12-17 Years	61.00%	60.00%	69.49%	64.94%	31.19%	57.32%
Total	58.71%	56.20%	66.87%	65.19%	36.36%	56.67%
Utilization						
Well-Child Visits in the First 15 Months of Life (w15)						
0 Visits	0.73%	0.00%	0.85%	1.83%	2.66%	1.21%
1 Visit	1.95%	0.97%	0.56%	0.91%	2.39%	1.36%
2 Visits	1.95%	1.95%	2.82%	3.35%	3.19%	2.65%
3 Visits	3.89%	3.41%	1.69%	2.44%	3.46%	2.98%
4 Visits	9.00%	5.60%	5.65%	4.27%	9.84%	6.87%
5 Visits	9.98%	11.68%	14.97%	8.23%	15.16%	12.00%
6+ Visits	72.51%	76.40%	73.45%	78.96%	63.30%	72.92%
Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life (w34)	59.85%	64.58%	65.57%	76.72%	65.63%	66.47%

NA= Data not available; NR= Not Reported; BR= biased rate; * indicates small denominator for rate calculation; -- indicates HEDIS 2019 rate used per NCQA allowance

The comparison from the 2019 rates to the 2020 rates highlighted in green showed a substantial improvement of more than 10% year over year. The rates highlighted in red indicate a substantial decrease in the rate of more than 10%. *Table 27* highlights the HEDIS measures with substantial increases or decreases in rate from last year to the current year.

Table 27: HEDIS Measures with Substantial Changes in Rates

Measure/Data Element	ATC	Healthy Blue	Molina	Select Health	WellCare	Statewide Average
Effectiveness of Care: Prevention and Screening						
Adult BMI Assessment (aba)	87.35%	87.35%	93.08%	87.76%	77.91%	86.69%
Effectiveness of Care: Respiratory Conditions						
Medication Management for People With Asthma (mma)						
19-50 Years - Medication Compliance 50%	60.50%	58.38%	63.13%	58.26%	45.54%	57.16%
Asthma Medication Ratio (amr)						
12-18 Years	71.72%	72.65%	69.80%	64.19%	56.93%	67.06%
19-50 Years	60.16%	49.21%	53.33%	56.11%	39.73%	51.71%
51-64 Years	61.84%	55.22%	47.87%	47.15%	38.78%	50.17%
Total	72.68%	70.40%	68.94%	67.28%	59.49%	67.76%
Effectiveness of Care: Cardiovascular Conditions						
Persistence of Beta-Blocker Treatment After a Heart Attack (pbh)	79.37%	NA*	64.29%	77.66%	73.68%*	73.77%
Statin Therapy for Patients With Cardiovascular Disease (spc)						
Statin Adherence 80% - 40-75 years (Female)	63.97%	55.56%	48.59%	54.49%	44.55%	53.43%
Statin Adherence 80% - Total	61.58%	59.32%	47.90%	57.55%	48.37%	54.94%
Effectiveness of Care: Diabetes						
Blood Pressure Control (<140/90 mm Hg)	55.66%	56.69%	55.46%	60.29%	55.38%	56.70%
Statin Therapy for Patients With Diabetes (spd)						
Statin Adherence 80%	60.30%	52.38%	47.06%	53.12%	47.14%	52.00%
Effectiveness of Care: Behavioral Health						
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence (fua)						
30-Day Follow-Up: Total	11.81%	39.32%	14.61%	15.86%	17.08%	19.74%
7-Day Follow-Up: Total	7.09%	31.07%	10.05%	11.05%	12.73%	14.40%
Diabetes Monitoring for People With Diabetes and Schizophrenia (smd)	72.88%	65.36%	72.09%	71.11%	64.86%	69.26%

Measure/Data Element	ATC	Healthy Blue	Molina	Select Health	WellCare	Statewide Average
Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia (smc)	75.00%	NA*	NA*	83.33%*	88.89%*	75.00%
Effectiveness of Care: Overuse/Appropriateness						
Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis (aab)						
Total	49.22%	49.28%	45.49%	45.81%	46.01%	47.16%
Access/Availability of Care						
Initiation and Engagement of AOD Dependence Treatment (iet)						
*Alcohol abuse or dependence: Initiation of AOD Treatment: 13-17 Years**	NA	NA*	NA*	25.53%	36.84%	31.19%
*Alcohol abuse or dependence: Engagement of AOD Treatment: 13-17 Years**	NA	NA*	NA*	5.32%	21.05%	13.19%
Opioid abuse or dependence: Initiation of AOD Treatment: Total	43.95%	52.24%	57.44%	54.01%	44.52%	50.43%
Prenatal and Postpartum Care (ppc)						
Timeliness of Prenatal Care	93.67%	90.98%	99.76%	88.19%	93.19%	93.16%
Postpartum Care	78.83%	70.22%	83.21%	70.83%	74.94%	75.61%
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (app)						
12-17 Years	61.00%	60.00%	69.49%	64.94%	31.19%	57.32%
Total	58.71%	56.20%	66.87%	65.19%	36.36%	56.67%

NA= Data not available; * indicates small denominator for rate calculation

SCDHHS Withhold Measures

The plans were required to report 12 quality clinical withhold measures. Per the *SCDHHS Medicaid Playbook* and the *Policy and Procedure Guide for Managed Care Organizations*, individual measures within the quality index are weighted differently. A point value is assigned for each measure based on percentile (<10 Percentile = 1 point; 10-24% = 2 points; 25-49% = 3 points; 50-74% = 4 points; 75-90% = 5 points; >90% = 6 points). Points attained for each measure are multiplied by individual measure weights, then summed to obtain the quality index score. The 2019 rate, percentile, point value, and index score are shown in the tables that follow.

Table 28: ATC Quality Withhold Measures

Measure	MY 2019 Rate	MY 2019 Percentile	Point Value	Index Score
DIABETES				
Hemoglobin A1c (HbA1c) Testing	89.29	90	6	4.9
HbA1c Control (< =9)	42.34	50	4	
Eye Exam (Retinal) Performed	57.91	75	5	
Medical Attention for Nephropathy	90.79	50	4	
WOMEN'S HEALTH				
Timeliness of Prenatal Care	93.67	90	6	5.1
Breast Cancer Screen	62.64	75	5	
Cervical Cancer Screen	65.94	75	5	
Chlamydia Screen in Women (Total)	61.47	50	4	
PEDIATRIC PREVENTIVE CARE				
6+ Well-Child Visits in First 15 months of Life	72.51	75	5	3.3
Well Child Visits in 3rd,4th,5th & 6th Years of Life	63.75	10	2	
Adolescent Well-Care Visits	55.96	25	3	
Weight Assessment/Adolescents: BMI % Total	87.59	75	5	
BEHAVIORAL HEALTH				
Follow-Up After Hospitalization for Mental Illness - 7 Days	32.33	50	4	2.25
Initiation & Engagement of Alcohol & Other Drug Dependence Treatment - Initiation – Total	39.22	25	3	
Follow Up for Children Prescribed ADHD Medication – Initiation	44.08	25	3	
Continuation Phase-Antidepressant Medication Management - 180 Days (6 Months)	23.13	<10	1	
Metabolic Monitoring for Children & Adolescents on Antipsychotics - Total	25.08	10	2	
Use of First-Line Psychosocial Care for Children & Adolescents on Antipsychotics - Total	58.71	25	3	

Table 29: Healthy Blue Quality Withhold Measures

Measure	MY 2019 Rate	MY 2019 Percentile	Point Value	Index Score
DIABETES				
Hemoglobin A1c (HbA1c) Testing	86.86%	50	4	3.4
HbA1c Control (< =9)	46.47%	50	4	
Eye Exam (Retinal) Performed	41.12%	10	2	
Medical Attention for Nephropathy	89.78%	25	3	

Measure	MY 2019 Rate	MY 2019 Percentile	Point Value	Index Score
WOMEN'S HEALTH				
Timeliness of Prenatal Care	90.08%	90	6	3.9
Breast Cancer Screen	53.28%	25	3	
Cervical Cancer Screen	57.61%	25	3	
Chlamydia Screen in Women (Total)	56.20%	25	3	
PEDIATRIC PREVENTIVE CARE				
6+ Well-Child Visits in First 15 months of Life	76.4%	75	5	3.1
Well Child Visits in 3rd,4th,5th & 6th Years of Life	64.58%	10	2	
Adolescent Well-Care Visits	51.58%	25	3	
Weight Assessment/Adolescents: BMI % Total	80.29%	25	3	
BEHAVIORAL HEALTH				
Follow Up Care for Children Prescribed ADHD Medication- Initiation	42.08%	25	3	2.75
Antidepressant Medication Management Effective Continuation Phase Treatment	31.71%	25	3	
Use of First Line Psychosocial Care for children and Adolescents on Antipsychotics- Total	56.2%	25	3	
Metabolic Monitoring for Children and Adolescents on Antipsychotics- Total	27.76%	10	2	
Follow Up After Hospitalization for mental Illness- 7 Day Follow Up Total	31.45%	25	3	
Initiation and Engagement of AOD use or Dependence Treatment: Initiation Total	40.49%	25	3	

Table 30: Molina Quality Withhold Measures

Measure	MY 2019 Rate	MY 2019 Percentile	Point Value	Index Score
DIABETES				
Hemoglobin A1c (HbA1c) Testing	89.77%	90	6	5.05
HbA1c Control (< =9)	47.49%	25	3	
Eye Exam (Retinal) Performed	61.87%	90	6	
Medical Attention for Nephropathy	93.41%	75	5	
WOMEN'S HEALTH				
Timeliness of Prenatal Care	99.76%	90	6	4.35
Breast Cancer Screen	57.26%	25	3	
Cervical Cancer Screen	64.72%	50	4	
Chlamydia Screen in Women (Total)	60.82%	50	4	
PEDIATRIC PREVENTIVE CARE				
6+ Well-Child Visits in First 15 months of Life	73.45%	75	5	3.75

Measure	MY 2019 Rate	MY 2019 Percentile	Point Value	Index Score
Well Child Visits in 3rd,4th,5th & 6th Years of Life	65.57%	25	3	
Adolescent Well-Care Visits	57.91%	50	4	
Weight Assessment/Adolescents: BMI % Total	78.52%	25	3	
BEHAVIORAL HEALTH				
Follow Up Care for Children Prescribed ADHD Medication- Initiation	58.76	90	6	3.75
Antidepressant Medication Management Effective Continuation Phase Treatment	29.13%	25	3	
Use of First Line Psychosocial Care for children and Adolescents on Antipsychotics- Total	66.87%	75	5	
Metabolic Monitoring for Children and Adolescents on Antipsychotics- Total	26.92%	10	2	
Follow Up After Hospitalization for mental Illness- 7 Day Follow Up Total	35.67%	50	4	
Initiation and Engagement of AOD use or Dependence Treatment: Initiation Total	42.57%	50	4	

Table 31: Select Health Quality Withhold Measures

Measure	MY 2019 Rate	MY 2019 Percentile	Point Value	Index Score
DIABETES				
Hemoglobin A1c (HbA1c) Testing	89.35	90	6	4.45
HbA1c Control (< =9)	46.03	25	3	
Eye Exam (Retinal) Performed	55.42	50	4	
Medical Attention for Nephropathy	91.16	50	4	
WOMEN'S HEALTH				
Timeliness of Prenatal Care	88.19	75	5	4.35
Breast Cancer Screen	60.49	50	4	
Cervical Cancer Screen	68.71	75	5	
Chlamydia Screen in Women (Total)	59.98	25	3	
PEDIATRIC PREVENTIVE CARE				
6+ Well-Child Visits in First 15 months of Life	78.96	90	6	5.30
Well Child Visits in 3rd,4th,5th & 6th Years of Life	76.72	75	5	
Adolescent Well-Care Visits	65.84	90	6	
Weight Assessment/Adolescents: BMI % Total	79.9	25	3	
BEHAVIORAL HEALTH				
Follow Up Care for Children Prescribed ADHD Medication- Initiation Phase	44.38	25	3	3.25

Measure	MY 2019 Rate	MY 2019 Percentile	Point Value	Index Score
Antidepressant Medication Management Effective Continuation Phase Treatment	29.82	25	3	
Metabolic Monitoring for Children and Adolescents on Antipsychotics- Total	40.26	50	4	
Use of First Line Psychosocial Care for Children and Adolescents on Antipsychotics	65.19	75	5	
Follow Up After Emergency Department Visits for Mental Illness- 7 Day Total	42.20	90	6	
Initiation and Engagement of AOD Abuse or Dependence Treatment: Initiation Total	38.61	25	3	

Table 32: WellCare Quality Withhold Measures

Measure	MY 2018 Rate	MY 2018 Percentile	Point Value	Index Score
DIABETES				
Hemoglobin A1c (HbA1c) Testing	88.77	75	5	4.15
HbA1c Control (< =9)	41.85	50	4	
Eye Exam (Retinal) Performed	52.62	25	3	
Medical Attention for Nephropathy	91.23	50	4	
WOMEN'S HEALTH				
Timeliness of Prenatal Care	93.19	90	6	4.10
Breast Cancer Screen	57.04	25	3	
Cervical Cancer Screen	57.42	25	3	
Chlamydia Screen in Women (Total)	63.46	50	4	
PEDIATRIC PREVENTIVE CARE				
6+ Well-Child Visits in First 15 months of Life	63.3	25	3	3.10
Well Child Visits in 3rd,4th,5th & 6th Years of Life	65.63	25	3	
Adolescent Well-Care Visits	51.95	25	3	
Weight Assessment/Adolescents: BMI % Total	82.48	50	4	
BEHAVIORAL HEALTH				
Follow Up Care for Children Prescribed ADHD Medication- Initiation	38.18	10	2	2.50
Antidepressant Medication Management Effective Continuation Phase Treatment	27.58	10	2	
Use of First Line Psychosocial Care for children and Adolescents on Antipsychotics- Total	36.36	<10	1	
Metabolic Monitoring for Children and Adolescents on Antipsychotics- Total	32.12	25	3	
Follow Up After Hospitalization for mental Illness- 7 Day Follow Up Total	35.14	50	4	

Measure	MY 2018 Rate	MY 2018 Percentile	Point Value	Index Score
Initiation and Engagement of AOD use or Dependence Treatment: Initiation Total	38.93	25	3	

Performance Improvement Project Validation

42 CFR §438.330 (d) and §457.1240 (b)

Each health plan is required to submit its Performance Improvement Projects (PIPs) to CCME annually for review. CCME reviews the project documents received from each plan and validates and scores the submitted projects using a CMS-designed protocol that evaluates the validity and confidence in the results of each project. The 12 projects reviewed in 2020 - 2021 for the five plans are displayed in the tables that follow.

As noted in *Table 33: Results of the Validation of ATC's PIPS*, **ATC's** PIPs received scores within the High Confidence Range and met the validation requirements.

Table 33: Results of the Validation of ATC's PIPs

Project	Validation Score	Interventions
Postpartum Care	100/100=100% High Confidence in Reported Results	• Appointment reminder cards • Car seat incentive • Home visits • Provider education • New Mom Report
Provider Satisfaction	Not validated due to a delay in conducting the Provider Satisfaction Survey	• Provider education • Real-time care gap reports • Turnaround time metrics • Enhanced orientation
Hospital Readmissions	72/72=100% High Confidence in Reported Results	• Transition of Care team • Case management referrals • PCP outreach • Quarterly multidisciplinary team assessment of multiple re-admitters

ATC's Postpartum Care and new Hospital Readmissions PIP were validated during this EQR. The Postpartum Care PIP, designed to improve the rates for postpartum visits, did show an improvement in the rate although it was still below the benchmark rate. The Readmissions PIP had baseline data only and therefore improvement could not be

evaluated. There are several interventions underway for this PIP using ATC's Post Hospital Outreach Team to assess the member's needs before and after discharge, medication reconciliation with the primary care provider, and referrals to Case Management as needed.

Last year, it was noted that the rate for the Provider Satisfaction PIP decreased from baseline. ATC indicated the provider satisfaction workgroup met and interventions were discussed. For this EQR, CCME was unable to assess the effectiveness of those interventions because the provider satisfaction survey was delayed, and the results were not available for this review. Staff did indicate that preliminary results showed some improvements.

Healthy Blue's PIPs scored in the High Confidence in Reported Results range as displayed in *Table 34: Results of the Validation of Healthy Blue's PIPS*.

Table 34: Results of the Validation of Healthy Blue's PIPs

Project	Validation Score	Interventions
Access and Availability to Care	100/100= 100% High Confidence in Reported Results	• Live outreach phone calls • HealthCrowd IVE calls • Provider Gap in Care reports • ER diversion program • HEDIS documentation workshops
Comprehensive Diabetes Care	100/100=100% High Confidence in Reported Results	• In-Home Assessment • HealthCrowd Texting campaign • HEDIS coding seminar • Gift card incentives

The Access and Availability to Care PIP document received for this review contained additional measures and data. Staff indicated during the onsite that the additional information added to the PIP document was to monitor access in innovative ways, as this PIP is being replaced and will be closed for the subsequent review year. The PIP document showed improvement in the adult access to preventive (AAP) services measure although it is still below baseline and the CAHPS indicator improved slightly from the previous remeasurement to 85.32%, which is above the 81.97% goal. The other indicators that were added did not have a clear presentation of the indicator definitions, goals, benchmarks, and results were not clearly presented.

The Comprehensive Diabetes Care PIP showed improvement for the Hemoglobin A1c indicator from 85.16% to 85.86% and eye exam indicator from 36.74% to 41.12% although neither measure has achieved the goal rate.

This year, **Molina's** Well-Care Program and Breast Cancer Screening PIPs received a validation score within the High Confidence range. A new PIP, Correlation Between Member Assignment and Engagement, was validated and received a score within the Confidence range (see *Table 35: Results of the Validation of Molina's PIPs)*.

Table 35: Results of the Validation of Molina's PIPs

Project	Validation Score	Interventions
Breast Cancer Screening	73/74=99% High Confidence in Reported Results	• Provider Education • Member Incentive • Appointment assistance • Mobile mammogram events
Well-Care Program	80/80=100% High Confidence in Reported Results	• Gift card incentives • Member transportation • Member education • Provider incentives • Member reminder mailings
Correlation Between Member Assignment and Engagement	63/74=85% Confidence in Reported Results	• Update data system issues

For the Breast Cancer Screening PIP, the rate decreased in the most recent remeasurement from 58.83% to 57.26%. Several member and provider interventions have been initiated for this PIP including member outreach through postcard mailing and call campaigns, community engagement team calls, member incentives, and transportation assistance. The provider-related interventions included provider education through provider quality reports, HEDIS tip sheets and scorecards, and a quality engagement team (QET) that offer tool kits to educate providers. This PIP has been ongoing for several years and has shown little or no improvements on the breast cancer rates even with all the incentives and initiatives. It seems the QET appears to have a stronger impact on the rates than gift card incentives. Molina should consider continuing the effective interventions, monitoring the breast cancer screening rate, and replacing this PIP with another project focusing on a different priority population to continue improving the quality of care.

For the Well-Care Program PIP, most of the measures improved, except for the Adults Access to Preventive/Ambulatory Health Services measure. The interventions for this PIP are focused on incentives for the members, outreach, transportation assistance, and education. The provider interventions include incentives, education via HEDIS scorecards and the QET partnership, as well as education related to clinical and coding practices. Several measures in this PIP are being replaced or are retired (e.g., Children and

Adolescents' Access to Primary Care Practitioners measure). Molina indicated the health plan would document the changes and consider using new measures.

The Member Assignment and Engagement PIP documentation reported system limitations and data issues that are affecting accuracy of reported rates and member assignments. This PIP had the baseline and one remeasurement displayed in the report. Indicator one remained the same at 32%. Indicator two declined from 72% to 66%, and the goal is to increase that rate. Indicator three decreased from 85% to 47% and this is improvement, as the goal is to decrease indicator three. The interventions that align with specific data barriers were not presented in the PIP report, although it is evident from the analysis that the primary intervention is addressing data management and reporting. CCME requested Molina provide a quality improvement plan and display the specific data and system issues and aligned interventions to address those issues in the PIP report.

Select Health's PIPs scored in the High Confidence in Reported Results range as noted in *Table 36: Results of the Validation of Select Health's PIPs*.

Table 36: Results of the Validation of Select Health's PIPs

Project	Validation Score	Interventions
Diabetes Outcomes Measures	84/85=99% High Confidence in Reported Results	• Gift card incentive • Provider Education • Provider training on appropriate codes • HIE flat file data exchange • Implementation of year-round medical record review
Well Care Visits for Foster Care Population	83/83=100% High Confidence in Reported Results	• Gap-in-care reports • Care management roster • Formal data sharing agreement

The Diabetes Outcomes PIP showed a decline in the indicator rates from last year to this year. The report noted COVID-19 as a barrier to obtaining the records, which impacted the rates. CCME recommended Select Health continue the interventions and to work on ways to mitigate the impact of COVID-19 on data collection and data retrieval.

The Well Child Visits PIP reported the baseline year as 2020 and other year's rates were included to gather trends for the HEDIS based measures.

Table 37: Results of the Validation of WellCare's PIPs shows both PIPs validated for **WellCare** received a score within the High Confidence Range.

Table 37: Results of the Validation of WellCare's PIPs

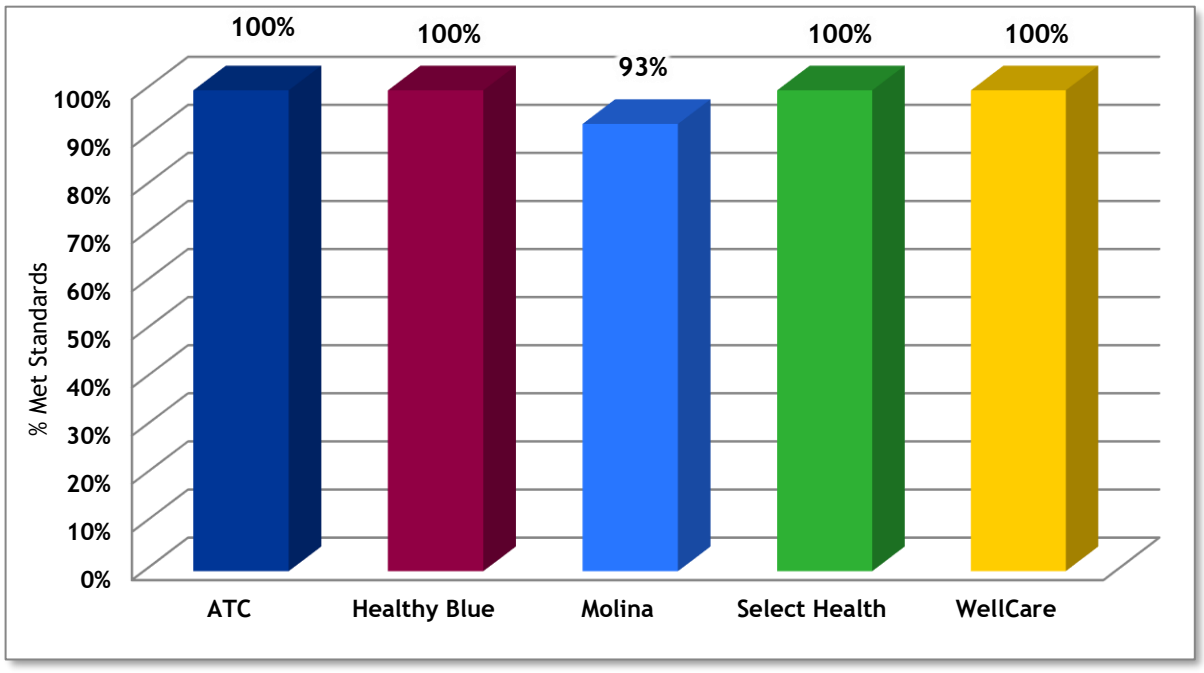
Project	Validation Score	Interventions
Improving Dilated Retinal Exam (DRE) Screening	73/73=100% High Confidence in Reported Results	• Member education • Transportation assistance • Provider education • Pilot in-home DRE screening • DRE incentive • Member outreach
Access to Care	80/80= 100% High Confidence in Reported Results	• Member education • Provider notifications • Care gap reports • Provider portal for member care-gaps • Provider compensation • Member gift card incentives

The rate for the Improving DRE Screening PIP was noted as unchanged from CY2018 to CY2019. According to WellCare, the project uses administrative rates, and the 2018 rate was reported for 2019 as allowed by NCQA. WellCare will continue the following in 2021: member outreach to remind members of the importance of needed DRE Screening; in-home assessments for DRE Screening when available; continued support of vision vendors efforts with member automated calls and provider outreach to include efforts for DRE CPT II coding; and rewarding members and providers (Healthy Rewards/P4Q Program) when DRE's are completed. Progress will be monitored by the HEDIS® Comprehensive Diabetes Care (sub-measure Dilated Retinal Exams) rates obtained through the Annual Audit Review Table (ART).

The rate for the Access to Care PIP showed a slight increase. Member incentives and outreach and provider education continue to have a slight impact on improving primary care visits. These interventions will continue.

Overall, the plans performed well in the QI section. *Figure 9: Quality Improvement* provides an overview of the plans' performance in the QI section. Molina's lower score was related to the Member Assignment and Engagement PIP validation score.

Figure 9: Quality Improvement



A comparison of the plans' scores for the standards in the Quality Improvement section is illustrated in *Table 38: Quality Improvement Comparative Data*. The table also indicates strengths, weaknesses, and recommendations related to quality, timeliness, and access to care.

Table 38: Quality Improvement Comparative Data

Standard	ATC	Healthy Blue	Molina	Select Health	WellCare	▶ = *Quality* ▶ = *Timeliness* ▶ = *Access to Care*
The Quality Improvement (QI) Program *42 CFR §438.330 (a)(b) and 42 CFR §457.1240(b)*						
The MCO formulates and implements a formal quality improvement program with clearly defined goals, structure, scope and methodology directed at improving the quality of health care delivered to members	Met	Met	Met	Met	Met	**Strength:** ▶ The health plans have QI program descriptions that described the programs' structure, accountabilities, scope, goals, and needed resources. The program descriptions are reviewed and updated at least annually.
The scope of the QI program includes investigation of trends noted through utilization data collection and analysis that demonstrate potential health care delivery problems	Met	Met	Met	Met	Met	
An annual plan of QI activities is in place which includes areas to be studied, follow up of previous projects where appropriate, timeframe for implementation and completion, and the person(s) responsible for the project(s)	Met	Met	Met ↑	Met	Met	
Quality Improvement Committee						
The MCO has established a committee charged with oversight of the QI program, with clearly delineated responsibilities	Met	Met	Met	Met	Met	
The composition of the QI Committee reflects the membership required by the contract	Met	Met	Met	Met	Met	
The QI Committee meets at regular quarterly intervals	Met	Met	Met	Met	Met	
Minutes are maintained that document proceedings of the QI Committee	Met	Met	Met	Met	Met	

Standard	ATC	Healthy Blue	Molina	Select Health	WellCare	▶ = *Quality* ▶ = *Timeliness* ▶ = *Access to Care*
Performance Measures *42 CFR §438.330 (c) and §457.1240 (b)*						
Performance measures required by the contract are consistent with the requirements of the CMS protocol "Validation of Performance Measures"	Met	Met	Met	Met	Met	
Quality Improvement Projects *42 CFR §438.330 (d) and §457.1240 (b)*						
Topics selected for study under the QI program are chosen from problems and/or needs pertinent to the member population	Met	Met	Met	Met	Met	**Strengths:** ▶ All the MCOs have performance improvement projects underway aimed at improving the care their members receive. Topics included postpartum care, diabetes, and well-care visits. ▶ Two MCOs have performance improvement projects that address access to care. Healthy Blue's Access and Availability to Care PIP showed improvement in the adult access to preventive (AAP) services measure although it is still below baseline and the CAHPS indicator improved slightly. ▶ Interventions for PIPs were planned and implemented for members, providers, and system-based components. Barrier analyses were detailed and thoughtful. **Weakness:** ▶ Indicator rates declined for several PIPs suggesting interventions were not yet effective. **Recommendations:**
The study design for QI projects meets the requirements of the CMS protocol "Validating Performance Improvement Projects"	Met	Met	Partially Met ↓	Met	Met	

Standard	ATC	Healthy Blue	Molina	Select Health	WellCare	▶ = *Quality* ▶ = *Timeliness* ▶ = *Access to Care*
						• Continue interventions as COVID restrictions are reduced to determine impact when restrictions are not in-place. • Conduct analyses to determine if specific interventions are more effective by isolating those interventions for a period of time (quarterly) and computing interim rates to assess impact. • Continue to monitor indices for Diabetes, Women's Preventive Health, and Children's Preventive Health; determine timeline for inclusion of Behavioral health index as part of the index withhold program.
Provider Participation in QI Activities						
The MCO requires its providers to actively participate in QI activities	Met	Met	Met	Met	Met	
Providers receive interpretation of their QI performance data and feedback regarding QI activities	Met	Met	Met	Met	Met	
Annual Evaluation of the QI Program *42 CFR §438.330 (e)(2) and §457.1240 (b)*						
A written summary and assessment of the effectiveness of the QI program for the year is prepared annually	Met	Met	Met ↑	Met	Met	
The annual report of the QI program is submitted to the QI Committee and to the MCO Board of Directors	Met	Met	Met	Met	Met	

Utilization Management

42 CFR § 438.210(a-e),42 CFR § 440.230, 42 CFR § 438.114, 42 CFR § 457.1230 (d), 42 CFR § 457. 1228, 42 CFR § 438.228,42 CFR § 438, Subpart F, 42 CFR § 457. 1260, 42 CFR § 208, 42 CFR § 457.1230 (c),42 CFR § 208, 42 CFR § 457.1230 (c)

CCME's assessment of the health plans' utilization management (UM) programs included UM policies and procedures, medical necessity determination processes, pharmacy requirements, care management programs, websites, and reviews of approval, denial, appeal, and care management files.

Each health plan has a UM program description specific to the Medicaid line of business. Additionally, plans have programs descriptions for specific UM services, such as case management, behavioral health, and population health management. The program descriptions define program structures, lines of authority, goals, objectives, and staff roles for physical health, behavioral health, and pharmaceuticals. Policies and procedures are in place to provide guidance and define how medical necessity determinations, appeals, and Case Management services are operationalized to provide services to members. UM processes and requirements are also included in member handbooks, provider manuals, and on websites.

Each health plan evaluates the UM program at least annually to assess strengths, effectiveness, and to identify opportunities for improvement. Evaluation results are reported to appropriate committees.

As noted in *Table 39*, WellCare had deficiencies during the 2019 - 2020 EQR related to timeliness of UM decisions documented in the Provider Manual. WellCare adequately addressed this issue by revising the Provider Manual.

Table 39: Previous Utilization Management Program QIP for WellCare

Standard	EQR Comments
V A. The Utilization Management (UM) Program	
1. The MCO formulates and acts within policies and procedures that describe its utilization management program, including but not limited to: 1.4 timeliness of UM decisions, initial notification, and written (or electronic) verification;	Requirements for service authorization time frames are described in Procedure SC22-HS-UM-025-PR-001, Service Authorization Decisions Procedure, Policy SC22-HS-UM-023, Inpatient Concurrent Review, the Member Handbook, and Provider Manual. However, the table on page 56 in the Provider Manual incorrectly lists the determination timeframe for concurrent reviews as 24 hours and extensions up to 72 hours. *Quality Improvement Plan: Revise page 56 in the Provider Manual to be consistent with the concurrent review timeframes in Policy SC22-HS-UM-023, Inpatient Concurrent Review and to meet requirements in the SCDHHS Contract, Sections 8.6.1.3* and *8.6.1.4.*

Standard	EQR Comments
WellCare Response: WellCare revised page 56 in the Provider Manual to be consistent with the concurrent review timeframes in Policy SC22-HS-UM 23 and the contract.	

Medical Necessity Determinations

42 CFR § 438.210(a-e),42 CFR § 440.230, 42 CFR § 438.114, 42 CFR § 457.1230 (d), 42 CFR § 457. 1228

Medical Directors are in place to provide appropriate oversight and supervision of physical and BH UM services. Medical necessity reviews of service authorization requests are conducted by appropriate utilization staff using InterQual, Milliman Care Guidelines (MCG), internal clinical criteria, or other established criteria. Consistency in criteria application and decision-making are regularly assessed by conducting inter-rater reliability (IRR) testing and audits for physician and non-physician reviewers. A discrepancy was noted for WellCare's IRR benchmark, documented as 85% in programs descriptions and program evaluations and as 95% in related policies.

The plans use the most current version of the Preferred Drug List (PDL) to fulfill pharmacy requirements. Each health plan has the PDL and the PDL Control Log accessible on their respective websites. CCME identified that ATC's processes for communicating negative PDL changes were not clearly defined in policies and the PDL Updates posted on the website included several "effective" dates that make it difficult to determine when the updates became effective. CCME offered recommendations to address these issues.

Review of approval and denial files reflected timely and consistent decision-making and notification. Approval notices were faxed to the provider and contained all required information. Adverse benefit determination notices were written in clear language for a layperson to understand.

As noted in *Table 40*, ATC had deficiencies during the 2019 - 2020 EQR related to pharmacy formulary restrictions. Documentation of requirements for communicating negative PDL changes in Policy CC.PHAR.10, Preferred Drug List was inconsistent with ATC's process. ATC addressed this issue by adequately revising the policy.

Table 40: Previous Medical Necessity Determinations QIP for ATC

Standard	EQR Comments
V. B Medical Necessity Determinations	

Standard	EQR Comments
6.1 Any pharmacy formulary restrictions are reasonable and are made in consultation with pharmaceutical experts	Evolve Pharmacy Solutions is the pharmacy benefit manager for ATC. Pharmacy benefit information is available in Policy SC.PHAR.09, Pharmacy Program, Policy CC.PHAR.10, Preferred Drug List, the Member Handbook, the website, and the Provider Manual. The Preferred Drug List (PDL) provides formulary restrictions indicating medications that require prior authorization, limitations, or step therapy. The process for members to obtain over-the-counter medications are described in the Member Handbook. During the onsite, CCME discussed the following issues: •Policy CC.PHAR.10, Preferred Drug List, page 3, indicates that PDL changes are communicated annually and that Negative PDL changes are only communicated to the member and their provider. However, the timeframe and communication method in the policy are not consistent with ATC's processes. ATC staff confirmed that their process is to communicate PDL changes 30 days before the effective date and changes are posted on the website in addition to notifying the impacted member and provider. •Preferred Drug List updates are posted on the website under the heading "Which Drugs Are Covered." This is not a prominent and easily accessible location for members to find PDL changes. •The Pharmacy Program Description, page 10, indicates ATC allows 30 days for new members to fill prescriptions that require prior authorization. However, the SCDHHS Managed Care Organizations Policy and Procedure Guide, Section 4.2.21.3 states, "the new MCO is required to honor existing prescriptions needing a Prior Authorization (PA) under the new plan's formulary for a period of no less than ninety (90) days." ATC staff confirmed that they received permission from SCDHHS to authorize prescriptions for new members for 30 days and 60 days when appropriate. *Quality Improvement Plan: To be consistent with ATC's processes and with requirements in the SCDHHS Contract, Section 4.2.21.2.3, edit page 3 in Policy CC.PHAR.10, Preferred Drug List to reflect that PDL changes are posted to the website 30 days before the intended effective date in addition to notifying the impacted member and provider*.
ATC Response: ATC's remediation consisted of the creation of an addendum to Corporate Pharmacy policy CC.PHAR.10 which was voted on and approved at the P&T meeting on April 7, 2020. The language in the addendum specifies: "Negative PDL changes (i.e. changes that result in restrictions or replacements) may be communicated only to affected members and their prescribing practitioners. Absolute Total Care Health Plan communicates negative PDL changes to affected members and their prescribing practitioners at least 30 days in advance." 5/1/20 - ATC updated the draft addendum to address the website as required by the SCDHHS contract. The draft addendum will be voted on at the P&T meeting scheduled 7/14/2020. The language in the addendum now specifies: "Negative PDL changes (i.e. changes that result in restrictions or replacements) may be communicated only to affected members and their prescribing practitioners. Absolute Total Care Health Plan communicates negative PDL changes to affected members and their prescribing practitioners at least 30 days in advance via health plan website."	

Appeals

42 CFR § 438.228, 42 CFR § 438, Subpart F, 42 CFR § 457. 1260

Each health plan has established policies defining processes for handling appeals of adverse benefit determinations that are consistent with requirements in the *SCDHHS Contract* and Federal Regulations. Procedures for filing appeals are clearly provided and consistently documented in policies, the Member Handbook, Provider Manual, and on the website. Standard appeals and resolution notices are provided within 30 calendar days of receipt and expedited appeals within 72 hours of receipt. Determination letters are written in language that is easily understood by a layperson and include instructions for requesting a State Fair Hearing.

Review of appeal files reflect timely acknowledgement, resolution, and notification of determination. Summaries of appeal actions, trends, and root causes are reported to the respective UM and Quality committees and are used to identify opportunities to improve quality of care and service.

During the most recent EQRs, two health plans had deficiencies in standards related to processing and handling appeals and with procedures for filing appeals. For Healthy Blue, appeal case file letters did not include the 10-day timeframe for members to supply new evidence, appeal case file letters were not mailed to members within 10 days of the plan receiving the appeal request, and member consent was not consistently obtained. For WellCare, the terms “Authorized Representative” and “Adverse Benefit Determination” were omitted or not clearly defined in documents. Additionally, the pharmacy acknowledgement letter template has incorrect timeframes for members to submit a written appeal notice following their oral appeal request. Minor issues included Healthy Blue’s website heading not clearly identifying the location of appeals information.

As noted in *Tables 41, 42* and *43*, three health plans had deficiencies in standards related appeal determinations during the 2019 - 2020 EQRs. Issues included staff not following processes related to appeal resolution letters and mailing case files to members (Healthy Blue), members not informed they can access their appeal case file prior to the resolution, and the inconsistent documentation of the address to submit written appeals (Molina), and staff not following timeliness guidelines for standard and expedited appeal resolution (WellCare). The plans revised documents and processes to address these deficiencies.

Table 41: Previous Appeal Determinations QIP for Healthy Blue

Standard	EQR Comments
V C. Appeals	
2. The MCO applies the appeal policies and procedures as formulated.	CCME's review of appeal files revealed several issues: •Although the Appeal Representative Form is included with acknowledgement letters, appeal requests submitted on behalf of the member were processed without obtaining signed Appeal Representative Forms, as specified on page 4 of Policy SC_GAXX_051. During the onsite teleconference, Healthy Blue staff confirmed signed authorized representative forms are required for appeal cases. •Expedited requests were processed as standard requests without notifying the member that the request was downgraded to a standard appeal timeframe of 30 days, as noted on page 6 of Policy SC_GAXX_051. During the onsite Healthy Blue confirmed two appeal files were received as expedited requests and entered as standard requests in error. One appeal file did not include documentation that the appeal was reviewed by or discussed with a Medical Director, as specified in Policy SC_GAXX_051, Member Appeal Process. During the onsite, Healthy Blue revealed there was a system routing error that prevented the appeal from being assigned to the Medical Director and the nurse documented the decision rationale on behalf of the Medical Director. Additional issues identified with appeal case files include: •Member letters mailed with case file documents correctly states, "You can give evidence, testify, and make legal or factual arguments in person and in writing about your case. You must do so before your appeal request is resolved." However, the letter does not indicate a timeframe or deadline when the member must respond with additional information. •Case file letters and Appeal Resolution notices were dated within a few days of each other, thus not allowing the member adequate time to respond and present new evidence before the case is resolved. For example, in appeal file #2 the case file letter is dated 12/23/19 and the resolution notice is dated 12/30/19, and in appeal file #6 the case file letter is dated 1/6/20 and the resolution notice is dated 1/7/20. •Appeal case files were sent to members without documentation that a signed medical record release was obtained, as specified on page 1 in Policy SC_GAXX_051. During the onsite teleconference, staff confirmed case files are automatically mailed members. ***Quality Improvement Plan: Ensure staff follow all appeals processes outlined in Policy SC_GAXX_051, Member Appeal Process, such as: obtaining signed Appeal Representative Forms, notifying members when an expedited appeal request is downgraded to a standard request, and ensuring medical necessity files are reviewed and documented by a physician.***

Standard	EQR Comments
	Healthy Blue Response: Case file letter was revised and is being reviewed internally prior to submission to SCDHHS (tracked under BSC-MEM-1902-20 SC AG Member Case File Ltr Upd). The Response Time Language will show member has 10 days to provide additional information from the date of the letter. ETA for completion 8/15/2020. Revised SC_GAXX_051 to include process for mailing appeal case files within 10 days of appeal receipt. Also, removed verbiage regarding "signed medical record release was obtained," as this is not contractual. Policy will go through approval process in Q3 2020. DRAFT attached. G&A department will be Implementing an appeal audit tool that will capture all contractual requirements to ensure compliance with all aspects of the contract and P&P. Implementation is scheduled for 8/1/2020.

Table 42: Previous Appeal Determinations QIP for Molina

Standard	EQR Comments
V C. Appeals	
1. The MCO formulates and acts within policies and procedures for registering and responding to member and/or provider appeals of an adverse benefit determination by the MCO in a manner consistent with contract requirements, including: 1.2 The procedure for filing an appeal;	The procedure for filing an appeal is documented in Policy MHSC-MRT-002, Standard Appeal Process, the Provider Manual, Member Handbook, and the member website. Page 3 of Policy MHSC-MRT-002, Standard Appeal Process states, "MHSC provides the member and his or her representative, as well as regulatory or oversight agencies, the member's case file, including medical records, other documents and records, and any new or additional evidence considered, relied upon, or generated by MHSC in connection with the appeal of the adverse benefit determination. MHSC provides this information free of charge and sufficiently in advance of the resolution timeframe for appeals as specified in §438.408(b) and (c)." The Member Handbook, appeal acknowledgement letters, and the Adverse Benefit Determination notice do not include information that members have access to the case file and other documents related to the appeal prior to the resolution timeframe, and CCME could not identify how Molina meets the requirement. During the onsite teleconference, Molina staff explained the member is informed of this requirement in the appeal resolution letter. The following issues are noted with addresses provided for members and providers to submit written appeals: •Neither the Member Handbook nor Policy or Procedure MHSC-MRT-002, Standard Appeal Process, includes an address where written appeals can be submitted. •The addresses to submit written appeals are slightly different in the Provider Manual, Adverse Benefit Determination letter

Standard	EQR Comments
	template, and the member website. The website has a physical street address and the other documents have a P.O. Box. •The Provider Manual and website state, "Molina Healthcare of South Carolina Attn: MIRR Dept." and the denial letter states, "Molina Healthcare Appeals dept." *Quality Improvement Plan: Ensure that members are informed they have access to their appeal case file and documents related to the appeal in advance of the resolution timeframe, as required by the SCDHHS Contract, Section 9.1.4.4.3, and stated in Policy MHSC-MRT-002, Standard Appeal Process. Include this requirement in documents such as the Member Handbook, appeal acknowledgement letters, and Adverse Benefit Determination notices. In the Member Handbook and Policy or Procedure MHSC-MRT-002, Standard Appeal Process, include an address where written appeals can be submitted.* *Ensure the address to submit written appeals is consistently documented in the Provider Manual, Adverse Benefit Determination letter template. and the member website.*
Molina Response: Updates have been submitted to update the member handbook and provider manual to include information advising members that they have access to their appeal case file and documents related to the appeal in advance of the resolution timeframe (handbook – pg. 53; manual – pgs. 103 and 105). The Member Handbook has been submitted to the State for review and approval. The A&G Acknowledgement letters have also been updated with this information and submitted for state review and approval. A&G P&P MHSC_002_Policy_Standard Appeals has been updated to include the address to where the Member Appeals can be submitted. The P&P has been approved by the A&P committee and submitted to the State for final approval. Updates to make the address in which to send member appeals and grievances consistent have been sent for the Provider manual and the member web site. The web site update has been approved and completed. 7/20/20 **Molina Response:** The Standard and Expedited Appeal Acknowledge Letter templates were updated to indicate a timeframe that members can request copies of their appeal files. The Notice of Adverse Benefit Determination (NOABD) letter was not submitted for the initial QIP response as it already contained the correct address for members to use to submit appeals (Molina's POB address). No edits were required. Please see the NOABD letter contained in folder 'Item 24'. Molina will take this recommendation under advisement and consider making this change in the future to appeals related documentation.	

Table 43: Previous Appeal Determinations QIP for WellCare

Standard	EQR Comments
V C. Appeals	

Standard	EQR Comments
1. The MCO formulates and acts within policies and procedures for registering and responding to member and/or provider appeals of an adverse benefit determination by the MCO in a manner consistent with contract requirements, including: 1.5 Timeliness guidelines for resolution of the appeal as specified in the contract;	Page 11, item VI (1) of Policy SC22-RX-012, Pharmacy Appeals incorrectly states standard appeal decisions that are adverse to the member, in whole or in part, are provided via written notice to the member no later than 72 hours from the receipt date. The correct timeframe for written notice of a standard appeal resolution is no more than 30 calendar days from the date of receipt of the appeal. Refer to the *SCDHHS Contract, Section 9.1.6.1.2.* Policy SC22-RX-012, Pharmacy Appeals does not address the requirement from the *SCDHHS Contract, Section 9.1.6.4.3* that if an expedited decision is not made within the established timeframe, the request is deemed approved as of the date a final decision should have been made. The Expedited Administrative Review Determination Denial Notice for pharmacy does not include the member's right to file a grievance if they disagree with the denial of the expedited review. The Time Frame Extension Notice for pharmacy does not include the member's right to file a grievance if they disagree with an extension. *Quality Improvement Plan: Correct the timeframe for written notice of resolution of a standard appeal on page 11 in item VI (1) of Policy SC22-RX-012, Pharmacy Appeals. Revise Policy SC22-RX-012, Pharmacy Appeals to include that if an expedited decision is not made within the established timeframe, the request is deemed approved as of the date a final decision should have been made. Revise the Expedited Administrative Review Determination Denial Notice for pharmacy to include the member's right to file a grievance if they disagree with the denial of the expedited review. Update the Time Frame Extension Notice for pharmacy to include the member's right to file a grievance if they disagree with an extension.*
WellCare Response: Policy SC22-RX-012 has been repealed and Policy HS-AP-002 has been updated to include Pharmacy Appeals. This policy already includse that if an expedited decision is not made within the established timeframe, the request is deemed approved as of the date a final decision should have been made. Expedited Administrative Review Determination Denial Notice for pharmacy includes the member's right to file a grievance if they disagree with the denial of the expedited review. Time Frame Extension Notice for pharmacy to include the member's right to file a grievance if they disagree with an extension is already included.	
1.6 Written notice of the appeal resolution as required by the contract;	Issues noted in Policy SC22-RX-012, Pharmacy Appeals include: •The policy does not address the requirement that for upheld and partially upheld resolutions, the MCO must send the notice

Standard	EQR Comments
	of appeal resolution to the member via certified mail, return receipt requested. •The policy does not include that the written notice of appeal resolution must include the right to request to receive benefits while the hearing is pending, and how to request this or an explanation that the member may be liable for cost of benefits if a State Fair Hearing decision upholds the MCO's adverse benefit determination. Refer to the *SCDHHS Contract, Sections 9.1.6.2.3.2.2 and 9.1.6.2.3.2.3.* •Page 11, item VI (1) (g) and page 14, item VIII (1) (g) do not include requirements specific to South Carolina. The Policy states, "The right to request the next level of review as specified by each State." *Quality Improvement Plan: Revise Policy SC22-RX-012, Pharmacy Appeals to include the requirement that for upheld and partially upheld resolutions, the MCO must send the notice of appeal resolution to the member via certified mail, return receipt requested. Also include that the written notice of appeal resolution must include the right to request to receive benefits while the hearing is pending, how to request continuation of benefits, and that the member may be liable for cost of benefits if a State Fair Hearing decision upholds the MCO's adverse benefit determination. Update page 11, item VI (1) (g) and page 14, item VIII (1) (g) to include specific South Carolina requirements that the next level of review is a State Fair hearing.*
WellCare Response: WellCare has repealed policy RX-012.Policy HS-AP-002 currently includes language outlinung the requirement that for upheld and partially upheld resolutions, the MCO must send the notice of appeal resolution to the member via certified mail, return receipt requested. The policy also includes that the written notice of appeal resolution must include the right to request to receive benefits while the hearing is pending, how to request continuation of benefits, and that the member may be liable for cost of benefits if a State Fair Hearing decision upholds the MCO's adverse benefit determination.	
1.7 Other requirements as specified in the contract.	The timeframe for requesting continuation of benefits during the appeal or State Fair Hearing process is incorrectly documented on page 70 of the Member Handbook and on the WellCare website. •The Member Handbook states, "Within 10 calendar days of the intended effective date of the plan's proposed action, whichever is later". •The website states, "within 10 calendar days of the intended effective date of the plan's proposed action whichever is later". The *SCDHHS Contract, Section 9.1.7.1.2* defines this requirement as, "The intended effective date of the CONTRACTOR's proposed Adverse Benefit Determination."

Standard	EQR Comments
	Quality Improvement Plan: Correct the timely filing requirement for continuation of benefits on page 70 of the Member Handbook and on the WellCare website.
WellCare Response: WellCare corrected the timely filing requirement for continuation of benefits on page 70 of the Member Handbook and on the website. 3/18/2020-WellCare has uploaded the Member Handbook to reflect timeframe to request the continuation of benefits.	
2. The MCO applies the appeal policies and procedures as formulated.	The following issues were noted in appeal files reviewed: •One expedited appeal with not resolved within the expedited appeal resolution timeframe with no documentation of denial of the expedited appeal request or of an extension of the resolution timeframe. •One expedited appeal was downgraded to a standard appeal with no notification the member. •One acknowledgement letter was not sent within the timeframe defined in WellCare policy. •One resolution for an appeal related to reimbursement for medication was determined to be incorrect based on discussion during the onsite visit. WellCare staff reported this resolution would have been appropriate for a Medicare member but not a Medicaid member. *Quality Improvement Plan: Ensure contractual and policy requirements are followed when processing member appeals. Ensure appeal resolutions are appropriate for members covered under the Medicaid line of business.*
WellCare Response: Wellcare has added additional monitoring reporting to ensure timely processing of appeal files to avoid missing established turn-around- time and ensure acknowledgement letters are created and mailed timely to members. Additonal monitoring/audits has been put in place to ensure the process to notify the member of the downgrade is completed.	

Case Management

42 CFR § 208, 42 CFR § 457.1230 (c)

The Care Management and Care Coordination programs focus on prevention, continuity of care, and coordination of services. Care management techniques are used to ensure comprehensive, coordinated care for all members in various risk levels. Population health management strategies are applied to ensure all eligible members have access to care management and care coordination. Additionally, processes are in place to address the requirements of Transition Care Management according to the *SCDHHS Contract, Section 5.6*. As the MCO provider for children in foster care, Select Health presented highlights of the positive impact from the Enhanced Foster Care Management Program.

The health plans adhere to definitions and standards from the Case Management Society of America (CMSA). CCME did not identify areas of noncompliance related to the plans'

CM programs. However, minor issues were noted, such as the CMSA definition of case management was inconsistently documented in policies and the Program Description (ATC), and responsibilities of the Transition Coordinator are not included in the Population Health Program Description and Complex Case Management Program Descriptions (Healthy Blue). CM files indicate care management activities are conducted by licensed clinical professionals who ensure that HIPAA verification, identifying care-gaps, and social determinants of health are consistently addressed.

During the current EQRs, CCME identified that requirements for Targeted Case Management (TCM) Services were omitted from Select Health's program descriptions and policies.

The health plans ensure UM programs are evaluated at least annually to assess strengths, effectiveness, and areas of opportunity. Results are reported to the respective quality committees. Even though isolated instances of staff not following UM guidelines were discussed during the onsites, CCME did not identify trends or patterns of noncompliance. Overall, no major issues were identified, and UM services are provided according to established processes and SCDHHS requirements.

Over/Under Utilization

The health plans are required to monitor and analyze utilization data to identify trends or issues that may provide opportunities for quality improvement. All health plans submitted information on quarterly or annual trending of utilization data across medical and behavioral health services. Policies for over and under-utilization were included within the utilization management departments, though evaluations and actions to improve utilization measures were stated to be a multi-department effort for all plans.

Each health plan analyzed and monitored utilization data for several services, and offered recommendations based on findings to their respective committees.

For ATC, utilization management focused on length of stay, admits/1000, days/1000, ER utilization/1000, 30-day readmissions, and neonate rates. Additional information was tracked for procedures such as tonsillectomy, hysterectomy, and total knee replacement.

For Healthy Blue, the following rates were examined: ER visits, Inpatient Discharges per 1,000 member months, and Frequency of Selected Procedures- Back Surgery, Bariatric Weight Loss Surgery, and Tonsillectomy. ER visits continue to decline; UM discharge planning with case management intervention will continue for acute care discharges. The selected procedures seem to be within standard utilization range for back surgery and tonsillectomy, with weight loss surgery rates reported as above the threshold for overutilization in males and females.

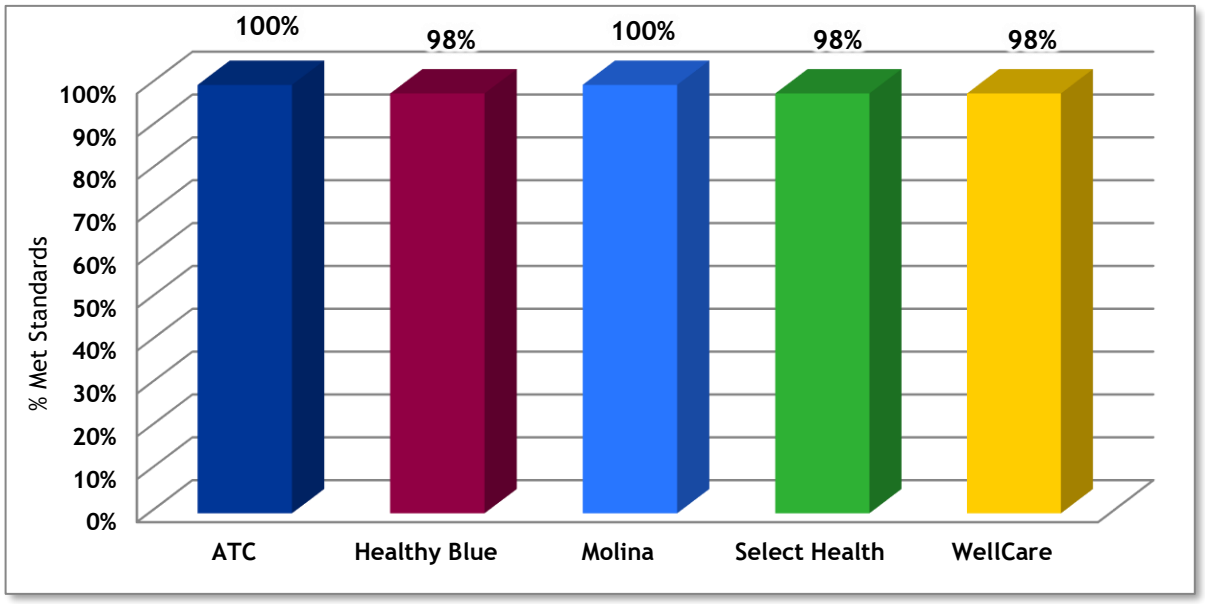
For Molina, the data in the current review year focused on ER utilization, Med/Surg Admissions, BH Admissions, and 30-day readmissions. The readmission rates were higher than goal rates as of the latest data. Admits were also an issue for the Aged, Blind and Disabled (ABD) population. The position regarding over- and under-utilization was filled in March 2021 and the plan is expecting improvement in readmission rates as contact with members is allowed via face-to-face with COVID restrictions lessening.

For Select Health, the UM Program Evaluation presented data on several utilization measures and noted efforts toward ED utilization reduction, as ED utilization increased in the most recent monitoring reports, in addition to total admissions and 30-day readmissions. Efforts to reduce over-utilization were documented in Select Health reports and committee meetings.

WellCare monitored and analyzed several outcomes including BH admissions, BH inpatient readmissions, medical inpatient readmissions, inpatient admissions/1000, ED utilization, and inpatient length of stay. Upon the review of the utilization management materials, WellCare offered recommendations based on internal analysis and findings for several services in regard to utilization in the committee meetings and in the program evaluation.

A comparison of all scores for the UM section is illustrated in *Table 10: Utilization Management Comparative Data*.

Figure 10: Utilization Management



A comparison of the plans' scores for the standards in the Utilization Management section is illustrated in *Table 44: Utilization Management Comparative Data*. The table also

indicates strengths, weaknesses, and recommendations related to quality, timeliness, and access to care

Table 44: Utilization Management Comparative Data

Standard	ATC	Healthy Blue	Molina	Select Health	WellCare	▶ = *Quality* ▶ = *Timeliness* ▶ = *Access to Care*
The Utilization Management (UM) Program						
The MCO formulates and acts within policies and procedures that describe its utilization management program, including but not limited to	Met	Met	Met	Met	Met	**Weakness:** ▶ Two plans had documentation issues related to pharmacy information, requirements, timeframes, and procedures (ATC, WellCare). **Recommendation:** • Ensure documentation of pharmacy requirements, procedures, timeframes, and definitions is correct.
Structure of the program and methodology used to evaluate the medical necessity	Met	Met	Met	Met	Met	
Lines of responsibility and accountability	Met	Met	Met	Met	Met	
Guidelines / standards to be used in making utilization management decisions	Met	Met	Met	Met	Met	
Timeliness of UM decisions, initial notification, and written (or electronic) verification	Met	Met	Met	Met	Met ↑	
Consideration of new technology	Met	Met	Met	Met	Met	
The absence of direct financial incentives or established quotas to provider or UM staff for denials of coverage or services	Met	Met	Met	Met	Met	
The mechanism to provide for a preferred provider program	Met	Met	Met	Met	Met	

Standard	ATC	Healthy Blue	Molina	Select Health	WellCare	= *Quality* = *Timeliness* = *Access to Care*
Utilization management activities occur within significant oversight by the Medical Director or the Medical Director's physician designee	Met	Met	Met	Met	Met	
The UM program design is periodically reevaluated, including practitioner input on medical necessity determination guidelines and grievances and/or appeals related to medical necessity and coverage decisions	Met	Met	Met	Met	Met	
Medical Necessity Determinations *42 CFR § 438.210(a-e),42 CFR § 440.230, 42 CFR § 438.114, 42 CFR § 457.1230 (d), 42 CFR § 457. 1228*						
Utilization management standards/criteria used are in place for determining medical necessity for all covered benefit situations	Met	Met	Met	Met	Met	**Strength:** ▶ Determination letters are written in language that is easily understood by a layperson and medical terminology is explained, when used.
Utilization management decisions are made using predetermined standards/criteria and all available medical information	Met	Met	Met	Met	Met	
Coverage of hysterectomies, sterilizations and abortions is consistent with state and federal regulations	Met	Met	Met	Met	Met	
Utilization management standards/criteria are reasonable and allow for unique individual patient decisions	Met	Met	Met	Met	Met	
Utilization management standards/criteria are consistently applied to all members across all reviewers	Met	Met	Met	Met	Met	

Standard	ATC	Healthy Blue	Molina	Select Health	WellCare	▶ = *Quality* ▶ = *Timeliness* ▶ = *Access to Care*
Any pharmacy formulary restrictions are reasonable and are made in consultation with pharmaceutical experts	Met ↑	Met	Met	Met	Met	
If the MCO uses a closed formulary, there is a mechanism for making exceptions based on medical necessity	Met	Met	Met	Met	Met	
Emergency and post stabilization care are provided in a manner consistent with the contract and federal regulations	Met	Met	Met	Met	Met	
Utilization management standards/criteria are available to providers	Met	Met	Met	Met	Met	
Utilization management decisions are made by appropriately trained reviewers	Met	Met	Met	Met	Met	
Initial utilization decisions are made promptly after all necessary information is received	Met	Met	Met	Met	Met	
A reasonable effort that is not burdensome on the member or the provider is made to obtain all pertinent information prior to making the decision to deny services	Met	Met	Met	Met	Met	
All decisions to deny services based on medical necessity are reviewed by an appropriate physician specialist	Met	Met	Met	Met	Met	
Denial decisions are promptly communicated to the provider and member and include the basis	Met	Met	Met	Met	Met	

Standard	ATC	Healthy Blue	Molina	Select Health	WellCare	▶ = *Quality* ▶ = *Timeliness* ▶ = *Access to Care*
for the denial of service and the procedure for appeal						
Appeals *42 CFR § 438.228, 42 CFR § 438, Subpart F, 42 CFR § 457. 1260*						
The MCO formulates and acts within policies and procedures for registering and responding to member and/or provider appeals of an adverse benefit determination by the MCO in a manner consistent with contract requirements, including	Met	Met	Met	Met	Met	**Weakness:** ▶ WellCare's and ATC's documentation of appeals information, requirements, and procedures contained errors, discrepancies, and omissions. **Recommendation:** • Ensure documentation of appeals requirements, procedures, and definitions is correct.
The definitions of an adverse benefit determination and an appeal and who may file an appeal	Met	Met	Met	Met	Met	
The procedure for filing an appeal	Met	Met	Met ↑	Met	Partially Met ↓	
Review of any appeal involving medical necessity or clinical issues, including examination of all original medical information as well as any new information, by a practitioner with the appropriate medical expertise who has not previously reviewed the case	Met	Met	Met	Met	Met	
A mechanism for expedited appeal where the life or health of the member would be jeopardized by delay	Met	Met	Met	Met	Met	
Timeliness guidelines for resolution of the appeal as specified in the contract;	Met	Met	Met	Met	Met ↑	
Written notice of the appeal resolution as required by the contract	Met	Met	Met	Met	Met ↑	
Other requirements as specified in the contract	Met	Met	Met	Met	Met ↑	

Standard	ATC	Healthy Blue	Molina	Select Health	WellCare	▶ = *Quality* ▶ = *Timeliness* ▶ = *Access to Care*
The MCO applies the appeal policies and procedures as formulated	Met	Partially Met ↑	Met	Met	Met ↑	
Appeals are tallied, categorized, analyzed for patterns and potential quality improvement opportunities, and reported to the Quality Improvement Committee	Met	Met	Met	Met	Met	
Appeals are managed in accordance with the MCO confidentiality policies and procedures	Met	Met	Met	Met	Met	
Case Management *42 CFR § 208, 42 CFR § 457.1230 (c)*						
The MCO formulates policies and procedures that describe its case management/care coordination programs	Met	Met	Met	Met	Met	**Strength:** ▶ Select Health reported the Enhanced Care Management for Children and Families in Foster Care program is having a positive impact. **Weaknesses:** ▶ For two health plans, case management terms are not consistently defined or described in policies and program descriptions, (ATC, Healthy Blue). ▶ Requirements for Targeted Case Management Services are not included in the Select Health's program description or in policies. **Recommendation:** • Ensure the definition of Case Management is consistently defined in Program Descriptions and policies, and the requirements for TCM
The MCO has processes to identify members who may benefit from case management	Met	Met	Met	Met	Met	
The MCO provides care management activities based on the member's risk stratification	Met	Met	Met	Met	Met	
The MCO utilizes care management techniques to ensure comprehensive, coordinated care for all members	Met	Met	Met	Partially Met ↓	Met	
The MCO has developed and implemented policies and procedures that address transition of care	Met	Met	Met	Met	Met	
The MCO has a designated Transition Coordinator who meets contract requirements	Met	Met	Met	Met	Met	

Standard	ATC	Healthy Blue	Molina	Select Health	WellCare	▶ = *Quality* ▶ = *Timeliness* ▶ = *Access to Care*
The MCO measures case management performance and member satisfaction, and has processes to improve performance when necessary	Met	Met	Met	Met	Met	services are included in applicable policies or other documents.
Care management and coordination activities are conducted as required	Met	Met	Met	Met	Met	
Evaluation of Over/Underutilization						
The MCO has mechanisms to detect and document under-utilization and over-utilization of medical services as required by the contract	Met	Met	Met	Met	Met	**Strength:** ▶ Health plans monitored and analyzed utilization data for over and under- utilization of medical services according to requirements in SCDHHS Contract. **Weakness:** ▶ Outcomes listed in the over and under-utilization monitoring policies were not always consistent with outcomes that were monitored and analyzed. **Recommendation:** • Edit policies to coincide with measures that are being monitored for utilization issues or monitor utilization measures that are documented in policies.
The MCO monitors and analyzes utilization data for under and over utilization	Met	Met	Met	Met	Met	

Delegation

42 CFR § 438.230 and 42 CFR § 457.1233(b)

Requirements for delegation of health plan functions, as well as processes for oversight of delegated entities, are documented in health plan policies and procedures. Once pre-delegation assessments are completed and delegation is approved, delegation agreements are implemented. The delegation agreements include general delegation terms and conditions, processes for ongoing monitoring, sub-delegation, reporting requirements, performance expectations, and actions that may be taken for unsatisfactory performance.

CCME reviewed documentation of oversight activities conducted by the MCOs for their delegates. There were no issues identified for ATC and Molina. Issues identified for the remaining plans included:

- Healthy Blue had inconsistent documentation of whether delegates were monitored for querying the National Plan and Provider Enumeration System (a repeat finding from the previous EQR) and SSDMF. Monitoring of delegates for collection of nurse practitioner collaborative agreements was also inconsistently documented.
- Select Health's Credentialing/Recredentialing file review tools used for delegation monitoring did not include the verification of the Clinical Laboratory Improvement Amendment (CLIA) Certificate and requirements for the nurse practitioners as required by health plan policy.
- WellCare's annual monitoring did not include a file review for a credentialing delegate and the audit tool used for the credentialing/recredentialing file review for other delegates did not include monitoring of all required queries.

For the previous reviews, the identified issues included

- Several MCOs' policies regarding delegation of credentialing and recredentialing activities did not include all credentialing requirements for which a delegate is responsible.
- Not conducting timely follow-up of issues identified during delegation oversight activities
- Oversight documentation lacking evidence that credentialing delegates are monitored for all required queries and website checks that must be conducted at initial credentialing and/or recredentialing
- Delegation oversight tools that did not specify the requirements to which a delegate is held, such as authorization turn-around times

The applicable health plans addressed the previous review findings during the QIP process, as noted in Tables 45, 46, and 47 below. Despite the QIP activities undertaken to address the previous review findings, Healthy Blue had one repeat deficiency identified on the most recent review.

Table 45: Previous QIP for Healthy Blue in the Delegation Area

Standard	Comments
2. The MCO conducts oversight of all delegated functions sufficient to ensure that such functions are performed using those standards that would apply to the MCO if the MCO were directly performing the delegated functions.	Processes and requirements for delegation oversight and monitoring are included in Policy HP 003-12, Oversight of Delegated Activities. Additional policies that address delegation monitoring and oversight include Policy MCD-10, Medicaid Delegated Credentialing, Policy A65, Pharmacy Benefit Manager (PBM) Performance Oversight, and the Utilization Management - Medicaid Delegation and Oversight policy. All potential delegates are subjected to a pre-delegation assessment of their operations, policies, reporting capabilities, and ability to perform the activities to be delegated. Once a delegation agreement is in place, annual oversight is conducted of each delegate. The annual review includes an assessment of the delegate's compliance with accreditation standards, contractual requirements, written policies and procedures, and quality activities related to the delegated functions and activities. For utilization and credentialing/recredentialing activities, the annual oversight includes file review to assess the delegate's compliance with contractual requirements, State and Federal regulations, and accreditation standards. In addition to annual oversight, delegates provide reports of delegated activities to the health plan on a predetermined schedule. If any deficiencies are identified, a corrective action process is initiated, and the delegate is informed in writing of the corrective action required and the timeframe for completion. CCME's review of delegate oversight documentation confirmed that, overall, appropriate processes are followed. It was noted that the MCO Credentialing File Review Workbook used to assess credentialing delegates does not indicate whether delegates are monitored for querying the National Practitioner Databank and the National Plan and Provider Enumeration System, as stated in Policy MCD-10, Medicaid Delegated Credentialing. ***Quality Improvement Plan: Ensure credentialing and recredentialing delegates are monitored for conducting required queries of the National Practitioner Databank and the National Plan and Provider Enumeration System. This should be documented in the MCO Credentialing File Review Workbook used to assess credentialing delegates.***

Standard	Comments
Healthy Blue's Response: Credentialing and Recredentialing delegates are monitored for conducting required queries of the National Practitioner Databank and the National Plan and Provider Enumeration System. The National Practitioner Databank review is currently reviewed for delegated entities and is captured on the Credentialing File Review Workbook (which we refer to as the Audit Tool). As discussed during the on-site, this is under Malpractice History, Sanctions, and Medicare/Medicaid on the Audit Tool. It was also discussed that we use the audit review tool provided by NCQA, which cannot be altered to specifically state "NPDB." But these are the three headings used to check for the NPDB queries with delegated entities. We have included National Plan and Provider Enumeration System review in the notes section of the MCO Credentialing File Review Workbook (Audit tool) used to assess credentialing delegates.	

Table 46: Previous QIP for Select Health in the Delegation Area

Standard	Comments
2. The MCO conducts oversight of all delegated functions sufficient to ensure that such functions are performed using those standards that would apply to the MCO if the MCO were directly performing the delegated functions.	Review of non-credentialing delegates (NIA, Citra, and BHM) revealed appropriate oversight and monitoring activities for NIA and Citra. Oversight documentation submitted for BHM revealed pre-delegation activities were completed in August 2018. The Delegate Performance Dashboard documentation for BHM states turn-around time performance for service authorizations exceeds the 90% goal monthly but does not define the timeliness requirements. Also, the dashboard shows Select Health is to monitor BHM's biannual IRR studies, but there was no evidence this is monitored in the dashboard documentation submitted. *Quality Improvement Plan: Ensure delegate oversight documentation for BHM includes evidence that Select Health monitors BHM's IRR studies and results.*
Healthy Blue's Response: Based on the recommendations and quality improvement plan, we have added the timeliness requirements goals to the dashboard to clearly define what the requirement is for each area. With the recent restructure of Delegation Oversight, we have implemented an updated process to ensure that the BHM IRR results are provided on the dashboard in a timely fashion. The IRR is set to be taken by BHM biannually and will be reported to Delegation Oversight upon completion of the testing.	

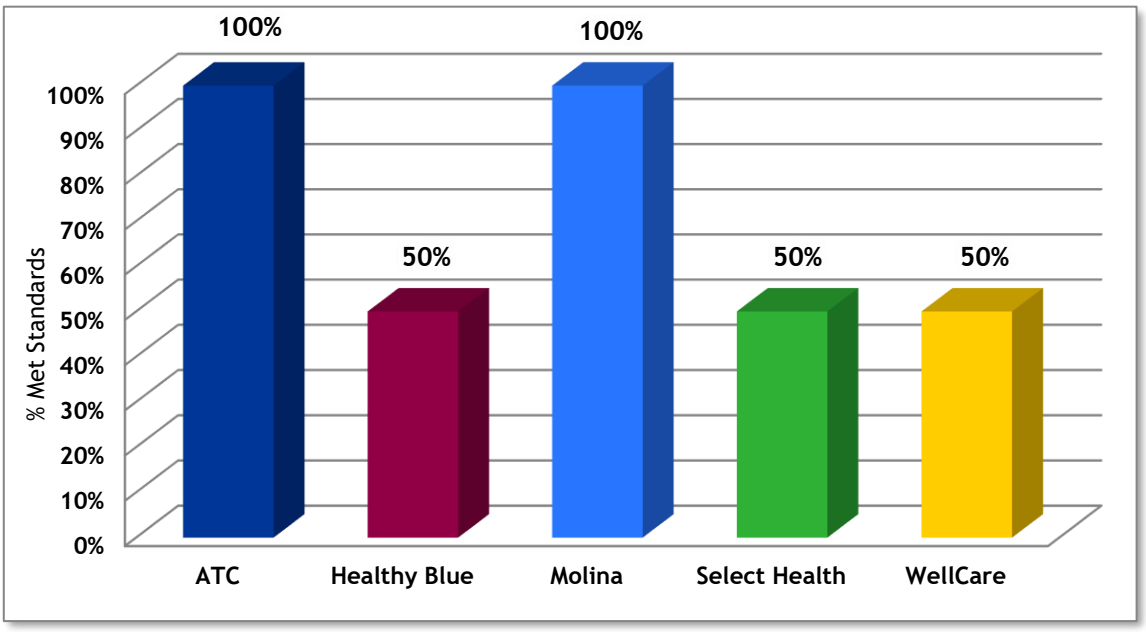
Table 47: Previous QIP for WellCare in the Delegation Area

Standard	Comments
2. The MCO conducts oversight of all delegated functions sufficient to ensure that such functions are performed using those standards that	WellCare's Policy SC22-CP-AO-007, Delegation Oversight and Procedure SC22-CP-AO-007-PR-001, Delegation Oversight Procedure define the process followed for pre-delegation,

Standard	Comments
would apply to the MCO if the MCO were directly performing the delegated functions.	annual oversight, and ongoing monitoring of delegated functions. WellCare submitted documentation of annual oversight of non-credentialing delegates. The documentation showed WellCare tracks metrics specific to the delegated services. Desk material documentation did not include monthly monitoring of delegates that provide call center functions (Teleperformance, The Results Companies). However, during the onsite visit WellCare staff stated it holds bi-weekly monitoring calls with the call center delegates. WellCare staff also provided the monthly dashboards they use for ongoing monitoring. WellCare performed annual delegation monitoring for all entities that handle credentialing and recredentialing. The audit tools used for oversight monitoring neither address the query of the SCDHHS List of Providers Terminated for Cause nor the Collaborative Agreement/Written Protocol for Nurse Practitioners. *Quality Improvement Plan: Update the credentialing and recredentialing audit tools to include the query of the SCDHHS List of Providers Terminated for Cause and the Collaborative Agreement/Written Protocol for Nurse Practitioners.*
Healthy Blue's Response: WellCare has updated the audit tools to include the query of the SC DHHS List of Providers Terminated for Cause and the Collaborative Agreement/ Written Protocol for Nurse Practitioners as found in the evidence submitted.	

As noted in *Figure 11: Delegation*, ATC and Molina scored "Met" for 100% of the Delegation standards. The remaining MCOs received "Met" scores for 50% of the Delegation standards.

Figure 11: Delegation



A comparison of the plans' scores for the standards in the Delegation section is illustrated in *Table 48: Delegation Comparative Data*. The table also indicates strengths, weaknesses, and recommendations related to quality, timeliness, and access to care.

Table 48: Delegation Comparative Data

Standard	ATC	Healthy Blue	Molina	Select Health	WellCare	▶ = *Quality* ▶ = *Timeliness* ▶ = *Access to Care*
Delegation *42 CFR § 438.230 and 42 CFR § 457.1233(b)*						
The MCO has written agreements with all contractors or agencies performing delegated functions that outline responsibilities of the contractor or agency in performing those delegated functions	Met	Met	Met	Met	Met	**Strength:** ▶ The MCOs have appropriate processes in place for pre-delegation assessment and implementation of written delegation agreements for all delegated entities. **Weaknesses:** ▶ Delegation oversight documentation does not reflect delegates are monitored for all required queries and collection of nurse practitioner collaborative agreements. ▶ For WellCare, annual monitoring of a credentialing delegate did not include a file review. **Recommendations** • Ensure delegation oversight tools document oversight for all requirements. • For oversight of credentialing delegates, ensure a file review is included.
The MCO conducts oversight of all delegated functions sufficient to ensure that such functions are performed using those standards that would apply to the MCO if the MCO were directly performing the delegated functions	Met	Partially Met	Met	Partially Met	Partially Met	

State Mandated Services

42 CFR Part 441, Subpart B

CCME reviewed requirements for State Mandated Services. The health plans' Early and Periodic Screening Diagnostic, and Treatment (EPSDT) Programs follow the American Academy of Pediatrics periodicity schedule for required screenings and services. Each health plan continuously monitors immunization and EPSDT compliance through frequent review of HEDIS metrics and provider performance on medical record reviews. The MCOs have several processes and provider engagement activities in place to educate, notify, and remind providers of needed EPSDT services.

Plans ensure core benefits and services are provided to members as required by the *SCDHHS Contract* and *42 CFR Part 441, Subpart B*. However, several state-of-emergency restrictions and guidelines related to the COVID-19 pandemic in 2020 may have contributed to pediatric provider compliance with performing EPSDT/Well Child visits and immunizations.

Every plan is required to address deficiencies identified in the previous EQR. In the current EQR period, the following issues were noted:

- ATC did not include all Status 1 provider types on the Geo Access mapping conducted on December 21, 2020.
- Healthy Blue did not correct issues relating to documentation of oversight of credentialing delegates.
- Select Health did not correct documentation of provider network geographic access standards in the Select Health of South Carolina Availability of Practitioners Report.

As noted in *Table 49* and *Table 50*, Molina and WellCare had deficiencies identified in the 2019 - 2020 EQR. Molina and WellCare adequately addressed these issues by revising methods for handling and processing grievances and appeals and working with the Quality Improvement and Compliance department to ensure that all deficiencies are addressed.

Table 49: Previous QIP for Molina in the State Mandated Services Area

Standard	Comments
3. The MCO addresses deficiencies identified in previous independent external quality reviews	A deficiency from the previous EQR related to closing member grievances prior to investigation and providing inadequate information in the member's notification of grievance resolution was found to be uncorrected. *Quality Improvement Plan: Ensure all deficiencies identified in the EQR are addressed.*

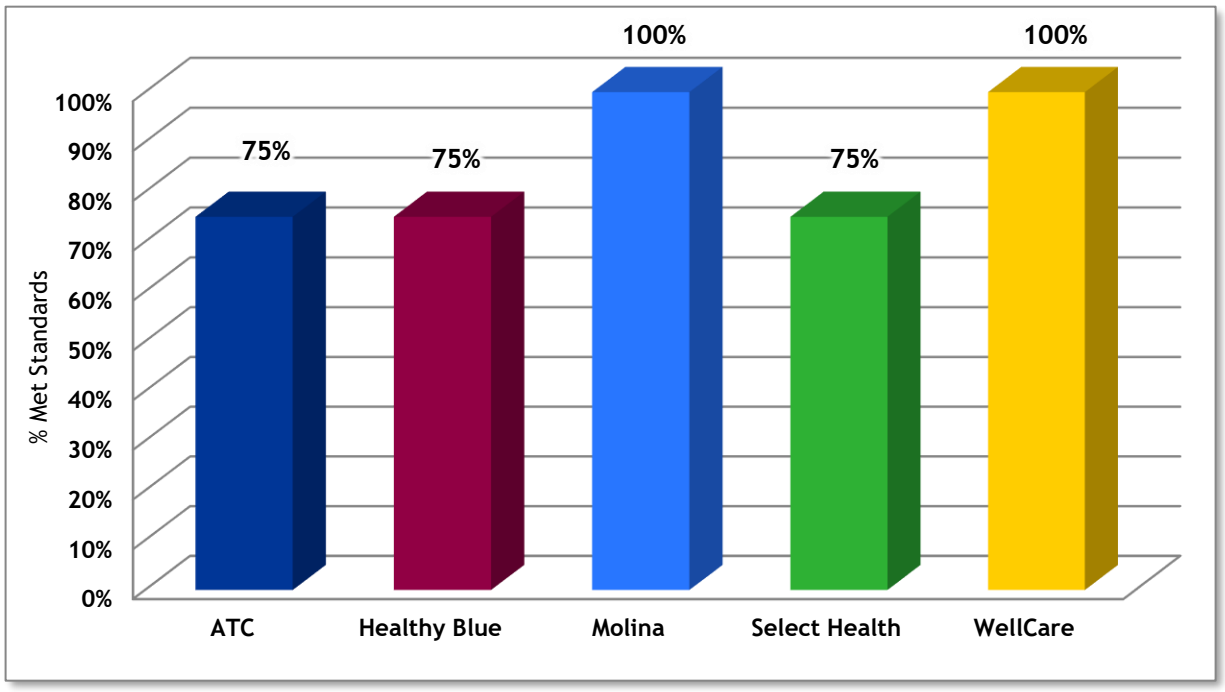
Standard	Comments
Molina Response: The A&G team will continue to send an email to the Provider Rep team email box attaching the Provider Service template with the appropriate information filled in. The Specialist will wait for the template to be returned to them from the Provider Rep team with the information filled out of what they have done to address the complaint from the member. The A&G Specialist will fully document in the A&G database the actions the Provider Rep has taken. A phone call will be made to the member to advise of the complete resolution of their complaint addressing all of the member's concern. The phone call conversation will be documented in the A&G database. If the member cannot be reached after three attempts, the current process of sending a resolution letter to the member will be followed. The letter will contain the information of the full resolution of the complaint from the member. The case in the A&G database will not be closed until all of the steps have been followed. An in-service training will be held with the grievance specialists and the Provider Service Reps to review the complete process when initiating contact with provider services. This training will be held by July 15th.	

Table 50: Previous QIP for WellCare in the State Mandated Services Area

Standard	Comments
3. The MCO addresses deficiencies identified in previous independent external quality reviews.	Issues identified in the previous EQR but not been corrected include: •The SCDHHS Contract requires health plans to query the SCDHHS List of Providers Terminated for Cause when credentialing or recredentialing a provider. CCME identified this issue during the 2018 EQR. The credentialing and recredentialing files reviewed during this EQR did not contain proof that the SCDHHS List of Providers Terminated for Cause was queried as required by the *SCDHHS Contract, 11.2.10.* *Quality Improvement Plan: Implement a process to ensure that all deficiencies identified during the EQR are addressed and corrections made.*
WellCare Response: WellCare works with the Quality Improvement and Compliance to be sure that all deficiencies are addressed. The files reviewed after May 2019 were representative of the process that was implemented after submitting the remediation plan for the 2018 EQR.	

Each plan's percentage of "Met" scores is demonstrated in *Figure 12: State-Mandated Services*.

Figure 12: State-Mandated Services



A comparison of the plans' scores for the standards in the State Mandated Services section is illustrated in *Table 51: Member Services Comparative Data*. The table also indicates strengths, weaknesses, and recommendations related to quality, timeliness, and access to care.

Table 51: State-Mandated Services Comparative Data

Standard	ATC	Healthy Blue	Molina	Select Health	WellCare	▶ = *Quality* ▶ = *Timeliness* ▶ = *Access to Care*
State Mandated Services *42 CFR Part 441, Subpart B*						
The MCO tracks provider compliance with administering required immunizations	Met	Met	Met	Met	Met	**Strength:** ▶ Health plans provided all core benefits required by the SCDHHS Contract. **Weakness:** ▶ ATC, Select Health, and WellCare did not address or correct deficiencies from the previous 2019 - 2020 EQR. **Recommendation:** • Ensure all identified deficiencies are addressed and corrected.
Performing EPSDTs/Well Care	Met	Met	Met	Met	Met	
Core benefits provided by the MCO include all those specified by the contract	Met	Met	Met	Met	Met	
The MCO addresses deficiencies identified in previous independent external quality reviews	Not Met ↓	Not Met ↓	Met↑	Not Met ↓	Met↑	

B. South Carolina Solutions

SCDHHS contracts with South Carolina Solutions (Solutions) to provide Primary Care Case Management (PCCM) and care coordination for the Medically Complex Children's Waiver (MCCW) Program. CCME's review focused on administrative functions, committee minutes, member and provider demographics, member and provider educational materials, and the Quality Improvement and Care Coordination/Case Management Programs. To access Solutions' compliance with the quality, timeliness, and accessibility of services, CCME's review was divided into four areas. The following is a summary of the review results for those areas. The tables reflect the scores for each standard evaluated in the EQR. The arrows indicate a change in the score from the previous review. For example, an arrow pointing up (↑) would indicate the score for that standard improved from the previous review and a down arrow (↓) indicates the standard was scored lower than the previous review. Scores without arrows indicate there was no change in the score from the previous review.

Administration

42 CFR § 438.224, 42 CFR § 438.242, 42 CFR § 438, and 42 CFR § 457

Solutions is a subsidiary of Community Health Solutions of America (CHS). The organizational structure and lines of communication are clearly outlined in the Organizational Chart. The South Carolina Solutions Medically Complex Children Waiver Program Description (MCCW Program Description) provides an overview of leadership and oversight roles. The Chief Medical Officer ensures the goals and objectives of SCDHHS, CHS, and Solutions are aligned and reports to the CHS Board of Directors, which has oversight of Solutions. Dr. Barbara Freeman is the Executive Director and Chief Medical Officer. The Medical Director, Dr. James Stallworth, provides clinical oversight and decision-making, and works closely with the Care Coordinator Team Leads. The Program Manager oversees the day-to-day operations of the program. The Organizational Chart does not display the position of Program Manager. Onsite discussion revealed the Care Coordinator Leads act as Program Managers.

Based on the Organizational Chart, Solutions employs 46 Care Coordinators overseen by three Care Coordinator Leads and 10 Care Advocates overseen by one Care Advocate Team Lead. Onsite discussion confirmed position vacancies included positions for two Care Coordinator and one Care Advocate. Solutions was recruiting to fill these positions.

Processes for new policy development and review are explained in in Policy CHS.ADM.ALL.01.01, Policy and Procedure Management. The Compliance Department is responsible for maintaining a master list of all policies and for overseeing the policy review process. Policies are reviewed at initial development and at least annually for

compliance with contractual, state, federal, and accreditation requirements. Compliance staff also log all policies into Healthicity. Staff are educated on company policies upon hire and as changes are made. Staff sign an attestation statement acknowledging receipt of changes.

Solutions maintains credentialing files for nursing staff to ensure valid, active credentials in accordance with applicable state regulations and URAC accreditation guidelines. Solutions provided a copy of a flowchart that illustrated the process for verifying qualifications of non-clinical staff. Policies detailed multi-level processes to verify nurse licensure at the time of employment and on an ongoing basis and described processes followed if nurse licensure is not renewed or if there are adverse licensure changes. Ten personnel files were randomly selected and reviewed. No issues were identified.

The Human Resources Department conducts initial exclusions review and the Compliance department conducts monthly exclusion review to ensure that employees, vendors, contractors, and providers have not been sanctioned or excluded from participating in any federal or state health care program.

Solutions' HIPAA Security and Awareness Training program ensures all staff are aware of security policies and procedures and general principles of information security. All staff receive training about HIPAA and information security prior to being granted access to Protected Health Information, when responsibility is increased, when promoted or reassigned, and when systems or security policies and procedures change. Training occurs upon hire and annually. The Employee Handbook includes information about confidentiality and privacy of information, especially client information. The handbook states all employees are required to sign a Confidentiality/Privacy Agreement as a condition of employment and informs that improper use or disclosure of information will subject the employee to disciplinary action, up to and including termination of employment and possible legal action.

The 2020 Compliance Program document applies to the Premier Family of Companies, Community Health Solutions of America, Inc., and affiliates, and outlines the enterprise-wide Compliance Program. The Compliance Program's purpose is to ensure all employees in all lines of business fully understand the organizational commitment to conducting business ethically and in compliance with state and federal laws, regulations, contracts, and other legal requirements. The Employee Handbook includes information about expected conduct and ethical business behavior. Topics include anti-harassment, conflicts of interest, outside employment, confidentiality and privacy, solicitation, use of equipment and vehicles, etc. Policy CHS.COMP.ALL.01.05, Reporting Mechanisms, outlines methods available to staff, members, clients, network providers, vendors, and others to report suspected fraud or abuse.

The Compliance Officer ensures open and effective communication with all employees and routinely attends staff and management meetings, corporate events, and other functions that encourage open communication. The open-door policy is supported through regular communication between staff, management, and the Compliance Officer. A policy of non-retaliation is enforced for employees who report suspected or actual FWA or other non-compliance, and forums for anonymous reporting are available.

Information Systems Capabilities

42 CFR § 438.242, 42 CFR § 457.1233 (d)

Solutions has policies and procedures that address data, system, and information security, and access management. Additionally, the documentation provided by Solutions indicates the organization's physical security procedures adhere to industry best practices. Solutions has an extensive Continuity of Operations plan and based on the version history, the plan is regularly reviewed and updated. The organization successfully tested the recoverability of its operations while conducting a migration to Google cloud services. The principal of least privilege is a core aspect of the organization's access control.

Table 52: Administration/Organization Activities displays the scores for all standards in the Administration section of the 2020 EQR. The table also indicates strengths, weaknesses, and recommendations related to quality, timeliness, and access to care.

Table 52: Administration/Organization Activities

Standard	Score	▶ = *Quality* ▶ = *Timeliness* ▶ = *Access to Care*
General Approach to Policies and Procedures		
Policies and procedures are organized, reviewed, and available to staff	Met	
Organizational Chart / Staffing		
The organization's infrastructure complies with contract requirements. At a minimum, this includes designated staff performing the following activities: Administrative oversight of day-to-day activities of the organization	Met	
Pre-assessment	Met	
Care coordination and enhanced case management	Met	
Provider services and education	Met	

Standard	Score	▶ = *Quality* ▶ = *Timeliness* ▶ = *Access to Care*
Quality assurance	Met	
Designated compliance officer	Met	
The organization formulates and acts within policies and procedures which meet contractual requirements for verification of qualifications and screening of employees. At a minimum, the following are included: Criminal background checks are conducted on all potential employees	Met	
Verification of nursing licensure and license status	Met	
Screening all employees and subcontractors monthly to determine if they have been excluded from participation in state or federal programs	Met	
Ensuring Care Coordinators and Pre-Admission Screening staff meet all contract requirements	Met	
Ensuring staff are independent of the service delivery system and are not a provider of other services which could be incorporated into a participant's Person-Centered Service Plan	Met	
Employee personnel files demonstrate compliance with contract and policy requirements	Met	
Governing Board/Advisory Board		
The Organization has established a governing body or Advisory Board	Met	
The responsibility, authority, and relationships between the governing body, the organization, and network providers are defined	Met	
Contract Requirements		
The organization carries out all activities and responsibilities required by the contract, including but not limited to: Available by phone during normal business hours 8:30 am to 5:00 pm Monday through Friday	Met	**Weakness:** ▶ Policy CHS.CM.MCCW.05.01, Medically Complex Criteria-Onsite Supervisory Visits, does not include the ride-alongs noted in Policy CHS.CM.MCCW.05.02, Chart Review Process. **Recommendation:** • Revise Policy CHS.CM.MCCW.05.01 to
Adherence to contract requirements for holidays and closed days	Met	
Processes to conduct onsite supervisory visits within 5 days of receiving a request from SCDHHS	Met	

Standard	Score	▶ = *Quality* ▶ = *Timeliness* ▶ = *Access to Care*
Organization and participant record retention and availability as required by the contract	Met	reflect the process of conducting at least two annual ride-alongs with each Care Coordinator.
Participant materials written in a clear and understandable manner, and are available in alternate formats and translations for prevalent non-English languages	Met	
Processes are in place to ensure care coordination services are available statewide	Met	
Confidentiality		
The organization formulates and acts within written confidentiality policies and procedures that are consistent with state and federal regulations regarding health and information privacy	Met	
Data Systems/Security		
Policies, procedures and/or processes are in place for addressing data, system, and information security and access management	Met	**Strength:** ▶ Information System backups are tested regularly to ensure and verify the integrity of the data backup.
The organization has a disaster recovery and/or business continuity plan that has been tested and the testing documented	Met	
Compliance and Program Integrity		
The organization has policies/procedures in place designed to guard against fraud, waste, and abuse, and including the following: Written policies, procedures, and standards of conduct comply with federal and state standards and regulations	Met	Strength: ▶ Training materials and processes for staff are clear and consistent. ▶ During the onsite discussion, SCDHHS reported that Solutions staff monitor for and report any suspected fraud, waste, and abuse and that this is invaluable in the investigation, resolution, and reduction of potential violations throughout the state.
A compliance committee that is accountable to senior management	Met	
Employee education and training that includes education on the False Claims Act, if applicable	Met	
Effective lines of communication between the compliance officer and the organization employees, subcontractors, and providers	Met	
Enforcement of standards through well-publicized disciplinary guidelines	Met	
Provisions for internal monitoring and auditing	Met	

Standard	Score	▶ = Quality ▶ = Timeliness ▶ = Access to Care
Provisions for prompt response to detected offenses and development of corrective action initiatives	Met	
A system for training and education for the Compliance Officer, senior management, and employees	Met	
Processes for immediate reporting of any suspicion or knowledge of fraud and abuse	Met	
The organization reports immediately any suspicion or knowledge of fraud or abuse	Met	

Provider Services

Solutions has established processes for conducting initial provider orientation and training at hire and updating providers at least annually about any changes to the program. The Provider Manual is a resource for program information and includes an overview of Solutions, the Medically Complex Children's Waiver, and Enhanced Primary Care Case Management. It also includes contact information, medical recordkeeping requirements and retention timeframes, and information about language interpretation services for verbal and written communications. Solutions' website did not have the current Provider Manual posted—the version on the website was dated 2019.

During the onsite, Solutions discussed plans to revise provider contracts to incorporate new requirements related to reporting of encounter data, etc. and stated provider representatives will be hired to conduct provider training. The Provider Manual is also being revised to capture new information that providers will need to understand new requirements and to provide services to the MCCW client population.

Table 53: Provider Services displays the scores for all standards in the Provider Services section of the 2021 EQR. The table also indicates strengths, weaknesses, and recommendations related to quality, timeliness, and access to care.

Table 53: Provider Services

Standard	Score	▶ = Quality ▶ = Timeliness ▶ = Access to Care
The organization formulates and acts within policies and procedures related to initial and ongoing education of providers	Met	**Strength:** ▶ Solutions plans to employ provider representatives to

Standard	Score	▶ = *Quality* ▶ = *Timeliness* ▶ = *Access to Care*
Initial provider education includes: Organization structure, operations, and goals	Met	educate providers about upcoming changes in provider requirements as well as the MCCW program in general. **Weakness:** ▶ An outdated version of the Solutions Provider Manual was on the website. **Recommendation:** • Ensure the website contains current documents.
Medical record documentation requirements, handling, availability, retention, and confidentiality	Met	
How to access language interpretation services	Met	
The organization provides ongoing education to providers regarding changes and/or additions to its programs, practices, standards, policies and procedures	Met	

Quality Improvement

For the Quality Improvement section, CCME reviewed the QI program description, committee structure and minutes, QI work plans, and the 2020 QI Program Evaluation. Solutions provided the 2021 Strategic Quality Plan. This plan serves as the QI program description and describes the program's structure, accountabilities, scope, goals, and available resources. The QI program description is reviewed and updated at least annually and approved by the Compliance and Quality Management Committee.

Solutions has two projects underway, including the SCS Onsite Quality Program Coordination Implementation project. The focus of this project is to implement a new quality management program to support early risk identification of compliance deficiencies and solidify a comprehensive retraining program. The Enhanced Provider Network Programs Modifications project is aimed at implementing a new medical informatics program to confirm provider contract compliance and identify opportunities to improve access to care.

Solutions' QI work plan identifies activities related to program priorities for addressing and improving the quality and safety of clinical care and services. The 2020 and 2021 Work Plans included the planned activity/project, interventions, start date, estimated completion, responsible parties, and quarterly updates. During the previous EQR, CCME recommended Solutions correct the estimated completion dates and include the quarterly updates. The review of the 2021 Work Plan found the quarterly updates were added. However, the estimated completion dates for the Revision of Program Materials and the policy and procedure review activities were not updated. The quarterly updates for these activities indicated the activities were either delayed or an ongoing activity.

Annually, Solutions evaluates the overall effectiveness of the QI Program and reports this evaluation to the CQMC for recommendations and approval. Solutions' Quality and Performance Improvement Annual Report for Calendar Year 2020 was reviewed and approved by the CQMC in March 2021.

For this review period, Solutions achieved "Met" scores for all the standards for the Quality Improvement section as noted in *Table 54: Quality Improvement*. The table also indicates strengths, weaknesses, and recommendations related to quality, timeliness, and access to care.

Table 54: Quality Improvement

Standard	Score	▶ = *Quality* ▶ = *Timeliness* ▶ = *Access to Care*
The Quality Improvement (QI) Program		
The organization formulates and implements a formal quality improvement program with clearly defined goals, structure, scope and methodology directed at improving the quality of health care delivered to participants	Met	Strength: ▶ Quality improvement projects are initiated when opportunities to correct or improve services or processes are identified. Solutions had two projects underway.
An annual QI work plan is in place which includes activities to be conducted, follow up of any previous activities where appropriate, timeframe for implementation and completion, and the person(s) responsible for the activity	Met	
Quality Improvement Committee		
The organization has established a committee charged with oversight of the QI program, with clearly delineated responsibilities	Met	
The QI Committee meets at regular intervals	Met	
Minutes are maintained that document proceedings of the QI Committee	Met	
Annual Evaluation of the Quality Improvement Program		
A written summary and assessment of the effectiveness of the QI program for the year is prepared annually	Met	
The annual report of the QI program is submitted to the QI Committee	Met	

Care Coordination/Case Management

Solutions Waiver Program Description is very brief and gives an overview of Solution's Enhanced Primary Care Case Management (PCCM) program. Lines of responsibility and accountability within the MCCW Program are noted in the Program Description, on the Organizational Chart, and in the Provider Manual.

Solutions has policies that describe and outline the methods used to provide care coordination and case management services. However, CCME could not clearly identify documentation of Solutions' process for implementing, coordinating, and monitoring Person-Centered Service Plans (PCSPs) with participants and primary care providers, as well as processes for updating and evaluating PCSPs semiannually.

Solutions has policies describing intervals and requirements of participant outreach and home visits. However, assessments and monthly calls were conducted telephonically as an exception. The Plan is operating under the Appendix K Waiver due to COVID-19 restrictions, which allows for all outreach to be conducted telephonically as face-to-face visits have been suspended, including Team Conferences.

Table 55: Care Coordination/Case Management displays the scores for the Care Coordination/Case Management section of the review. The table also indicates strengths, weaknesses, and recommendations related to quality, timeliness, and access to care.

Table 55: Care Coordination/Case Management

Standard	Score	▶ = *Quality* ▶ = *Timeliness* ▶ = *Access to Care*
The organization formulates and acts within written policies and procedures and/or a program description that describe its care coordination and case management programs	Met	**Strength:** ▶ Participants are given required information and forms at the time of enrollment and receive information to access local and state-wide resources. ▶ Care Coordination and Case Management activities occurred timely despite COVID-19 restrictions, which allows for all outreach to be conducted telephonically as face-to-face visits have been suspended.
Policies and procedures and/or the program description address the following: Structure of the program	Met	
Lines of responsibility and accountability	Met	
Goals and objectives of Care Coordination/Case Management	Met	
Intake and assessment processes for Care Coordination/Case Management	Met	
Providing required information to participants at the time of enrollment	Met	

Standard	Score	▶ = *Quality* ▶ = *Timeliness* ▶ = *Access to Care*
Minimum standards for phone contacts, in-home visits, and physician/nurse plan oversight as applicable	Met	**Weaknesses:** ▶ Documentation of process for implementing, coordinating, monitoring, evaluating, and updating PSCPs with participants, PCPs and SCDHHS is very minimal and confusing. ▶ PCP involvement in the PCSP process is not clearly described or documented. **Recommendations:** • Clearly document, in a policy or other document, Solutions' process for implementing, coordinating, monitoring, evaluating, and updating PSCPs according to requirements in Appendix A, Section D (1) (f) of the Medicaid HCBS Waiver Services Care Coordination Contract. • Edit the Provider Manual to correctly reflect the PCPs participation in PCSPs.
Processes to develop, implement, coordinate, and monitor individual Person-Centered Service Plans with the participant/caregivers and the PCP	Met	
Processes to ensure caregiver/parent participation in and understanding of the Person-Centered Service Plans	Met	
Process to regularly update and evaluate the Person Centered Service Plans on an ongoing basis	Partially Met ↓	
Processes for following up with participants admitted to the hospital and actively participate in discharge planning	Met	
Processes for reporting suspected abuse, neglect, or exploitation of a participant	Met	
A back-up service provision plan to ensure that the Participant receives the authorized care coordination services and a process to notify SCDHHS if services cannot be provided	Met	
The organization provides a written, formal evaluation of the Person Centered Plan to SCDHHS every 6 months or upon request	Met	
The organization conducts Care Coordination and Case Management functions as required by the contract	Met	

C. Coordinated and Integrated Care Organizations Annual Review

For this contract year, CCME conducted an External Quality Review of the Coordinated and Integrated Care Organizations (CICOs) that provider services for the dual eligible Medicare/Medicaid population. Those organizations included ATC, Molina, and Select Health. This review focused on network adequacy for home and community-based service (HCBS) and behavioral health providers, over- and under-utilization, and care transitions.

To conduct the review, CCME requested desk materials from each CICO. These items focused on administrative functions, committee minutes, member and provider demographics, over and under-utilization data, and care transition files.

Standards were scored as meeting all requirements ("Met"), acceptable but needing improvement ("Partially Met") or failing a standard ("Not Met"). An overview of the

findings for each section follows. The tables reflect the scores for each standard evaluated in the EQR. The arrows indicate a change in the score from the previous review. For example, an arrow pointing up (↑) would indicate the score for that standard improved from the previous review and a down arrow (↓) indicates the standard was scored lower than the previous review. Scores without arrows indicate there was no change in the score from the previous review.

Provider Network Adequacy

The CICOs are required by contract to maintain a network of HCBS providers that is sufficient to provide all enrollees with access to a full range of covered services in each geographic area. The CICOs are also required to have a network of BH providers to ensure a choice of at least two providers located within no more than 50 miles from any enrollee unless the plan has a SCDHHS-approved alternative standard.

SCDHHS established minimums for the HCBS of at least two providers for each service in each county except Anderson, Charleston, Florence, Greenville, Richland, and Spartanburg counties. For these larger counties, the minimum was established as three providers for each service. The minimum number of required providers for each active county was calculated and compared to the number of current providers for seven different services:

- Adult Day Health
- Case Management
- Home Delivered Meals
- Personal Care
- Personal Emergency Response System (PERS)
- Respite
- Telemonitoring

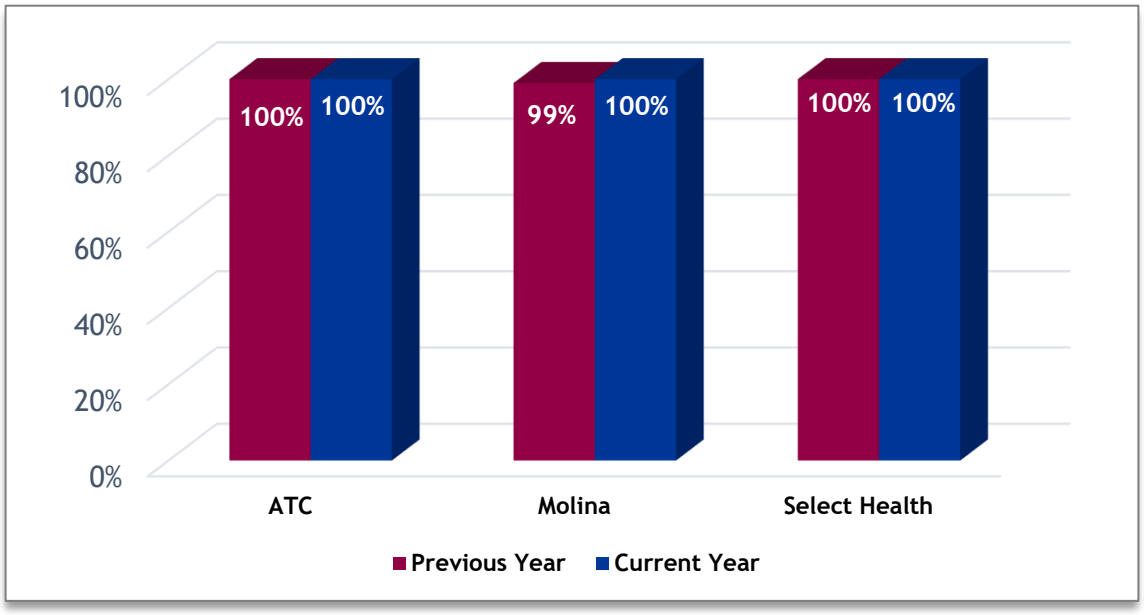
The file received from ATC contained approximately 5,000 providers. The preliminary analysis found the minimum requirements for an adequate network were not met. CCME followed up with ATC regarding the provider file received and requested verification that a complete list of contracted HCBS providers was received. A replacement provider file was not received until the week of the onsite. An analysis of the replacement file found ATC reported membership in 37 counties. Of the 259 services across 37 counties, 259 (100%) met the minimum requirements. This resulted in a validation score of 100%, which is a sustained rate from last year's rate of 100%.

Molina reported 45 counties as having enrollment in the MMP Member Demographics 2020 file submitted with the desk materials. Of the 315 services across 45 counties, 315 met the minimum requirements, resulting in a validation score of 100%. This was a 1% improvement from last year's rate of 99%.

For Select Health's network, the minimum number of required providers for each county was calculated and compared to the number of current providers for the seven different services. There were 46 counties that were documented as having members. Of the 322 services across 46 counties, 322 met the minimum requirements, resulting in a validation score of 100%, which is sustained from last year's rate of 100%.

The assessment is summarized in *Figure 13: HCBS Network Adequacy Review Results*.

Figure 13: HCBS Network Adequacy Review Results



The CICOs are also required to have a network of behavioral health providers to ensure a choice of at least two providers located within no more than 50 miles from any enrollee unless the plan has a SCDHHS-approved alternative time standard. All network providers must serve the target population (i.e., adults aged 65 and older) and at least one of the BH providers used to meet the two providers per 50-mile requirement must be a Community Mental Health Center (CMHC). All three CICOs met these requirements

Table 56, Provider Network Adequacy Comparative Data provides an overview of each plan's score for the Provider Network Adequacy section. The table also indicates strengths, weaknesses, and recommendations related to quality, timeliness, and access to care.

Table 56: Provider Network Adequacy Comparative Data

Standard	ATC	Molina	Select	▶ = *Quality* ▶ = *Timeliness* ▶ = *Access to Care*
Provider Network Adequacy				
The CICO maintains a network of Home and Community Based Services (HCBS) providers in each geographic area that is sufficient to provide all enrollees with access to a full range of covered services	Met	Met	Met	**Strength:** ▶ All CICOs demonstrated adequate provider networks to meet SCDHHS' requirements for HCBS and BH providers.
The CICO maintains a network of behavioral health (BH) providers in each geographic area that is sufficient to provide all enrollees with access to a full range of covered services	Met	Met	Met	

Evaluation of Over- and Under-utilization

The CICOs are required to monitor and analyze utilization data to look for trends or issues that may provide opportunities for quality improvement. The over- and under-utilization monitoring focuses on five key indicators: 30-day hospital readmission rates for any potentially avoidable hospitalization, length of stay for hospitalizations, length of stay in nursing homes, emergency room utilization, and the number and percentage of enrollees receiving mental health services.

ATC's files initially submitted contained reports on utilization for three of the five required services. Those included the 30-day readmission rate, length of stay for hospitalizations, and the percentage of members receiving mental health services. The 30-day readmission rate was below the expected utilization at 12.89% (goal is <17%). Length of stay was well above goal rate of 13.3 at 15.1 bed days. Admits per 1,000 was above the expected utilization (785) at 798 year-to-date (YTD). Days per 1000 was above the goal of 10,429 at 11,972 YTD. Penetration rate for BH services was at 1.2% for the last measurement in November 2020. The emergency room utilization and length of stay for nursing homes were not included in the desk materials and were requested onsite. The rates were uploaded after the onsite and reviewed. The 2019 Medicare QI Evaluation included information on interventions and recommendations based on utilization data monitoring.

The files submitted by Molina contained reports on utilization for the five required services as well as other services. The rates are monitored, trends are analyzed, and issues are identified. The length of stay for hospitalizations rate decreased from 7.2 to

6.8. For the length of stay in a skilled nursing facility, the rate declined from 19.9 to 18.1. The emergency room utilization rate declined from 3264 to 2756.

For mental health service utilization, the rate decreased from 1847/5796 (31.9%) to 878/5719 (15.4%). 30-day readmissions were included in the over/under report for Q3 and showed the readmissions per 1,000 was above the goal with 56 per 1,000, and the goal is 36 or fewer/1000. The readmission percentage is 13.3%, which is below the readmission percentage goal of 14.0%. Molina's Transition of Care (TOC) team are responsible for contacting members within 72 hours of discharge. Some of the barriers the TOC team has encountered is getting members engaged. This has resulted in a higher "unable to contact" rate.

Select Health submitted several different files showing the HEDIS and readmission data. The 30-day readmissions were reported and showed a decline from 1.6 in Calendar Year (CY) 2019 to 1.5 in CY 2020; ER utilization was at 5,733 for 2020. Length of stay was reported for acute and skilled nursing facilities; the BH services rate was 38.26%. The rates are monitored and there was adequate evidence in the desk materials that trends were analyzed, and issues were addressed to improve utilization rates. A specific deep dive analysis for ER utilization was documented, as well as monthly trending for length of stay and admissions.

All CICOs met the requirements for evaluating over- and under-utilization as shown in *Table 57: Evaluation of Over/Under Utilization Comparative Data*.

Table 57: Evaluation of Over/Under Utilization Comparative Data

Standard	ATC	Molina	Select	▶ = *Quality* ▶ = *Timeliness* ▶ = *Access to Care*
Evaluation of Over/Under Utilization				
The CICO monitors and analyzes utilization data to look for trends or issues that may provide opportunities for quality improvement. Utilization data monitored should include, but not be limited to: 30-day hospital readmission rates for any potentially avoidable hospitalization (enrollees readmitted with a diagnosis of Bacterial Pneumonia, Urinary Tract Infection, CHF, Dehydration, COPD/Asthma, and Skin Ulcers)	Met	Met	Met	

Standard	ATC	Molina	Select	▶ = Quality ▶ = Timeliness ▶ = Access to Care
Length of stay for hospitalizations	Met	Met	Met	
Length of stay in nursing homes	Met	Met	Met	
Emergency room utilization	Met	Met	Met	
Number and percentage of enrollees receiving mental health services	Met	Met	Met	

Care Transitions

For the care transitions review, CCME reviewed each CICOs program descriptions and policies related to care transitions. The CICOs were also required to submit a file of enrollees who were hospitalized in an acute care setting, discharged, and readmitted to an acute care facility within 30 days. The CICOs were directed to only include those enrollees readmitted with a diagnosis that met the definition of a potentially avoidable hospitalization. These were defined by SCDHHS as: Bacterial Pneumonia, Urinary Tract Infection, CHF, Dehydration, COPD/Asthma, and Skin Ulcers. Based on the file received from each CICO, CCME requested a random sample of files for review.

All the CICOs had policies and processes established to conduct appropriate transition of care (TOC) functions as required by the SCDHHS Contract. The CICOs continued to meet this requirement and no issues were identified.

For the previous EQR, issues were identified in all the CICOs TOC files. The CICOs implemented Quality Improvement Plans (QIPs) to address the deficiencies. Starting with ATC, the tables that follow provides an overview of the previous findings and the actions taken to address the deficiencies.

Table 58: Previous Care Transitions QIP for ATC

STANDARD	EQR COMMENTS
III. Care Transitions	
1. The CICO conducts appropriate care transition functions, as defined by the CICO 3-Way Contract, Section 2.5 and 2.6, to minimize unnecessary complications related to care setting transitions.	Chart reviews revealed similar issues noted from previous EQRs such as untimely notifications of admission and discharge among UM and CM staff and between the Health Plan and the facilities, inconsistent outreach and collaboration with PCPs, inconsistent identification of a facility-based Care Managers, and inconsistent clinical follow-up within 72 hours. During the onsite, ATC acknowledged delays or lack of notifications from facilities continue to be challenging. ATC described several interventions were implemented during the course

STANDARD	EQR COMMENTS
	of 2019 to address and improve care transition issues such as, but not limited to: •A UM referral queue. •Provider relations continues to work with hospitals providing education related to timely notifications. •Notification of transition of care form faxed to primary care physician within 24 hours of notification. •Monthly audits reviews completed by internal medical management auditors. •Several staff trainings. *Quality Improvement Plan: In order to comply with requirements in CICO 3-Way Contract, Section 2.6.9.7, continue to ensure clinical follow-up within 72-hours of transition is completed. Continue to implement and evaluate improvement processes that address communication between the health plan and facilities, and between internal departments (CM, UM, etc.). Continue to ensure files contain documentation of all faxed communication to the PCP's office.*
ATC Response: 1. Enhance process to demonstrate collaboration and documentation between internal departments for admissions, discharges and transfers. Supply reports and cases showing: a. Tasks sent between UM-TOC- CM b. SNP note type for collaboration. 2. Conduct consistent outreach to facilities to obtain real time discharge data a. Implemented team to call hospitals daily for discharges b .Revise documented process to ensure communication of real-time discharge information to TOC/PHO team, daily. 3. Revamped the consolidation all of MMP TOC outreach to one team under one manager. 4. Improve documented process to ensure consistent employee documentation of TOC activities a. Additional training b. Add auditing for 100% of all MMP TOCs 5. Collaborating with Provider Relations to identify points of contact at hospitals specific to discharge planning and TOC. 6. Revised documented process for faxing to treating providers for collaboration a. Fax form to Hospital for DC planning. b. Fax form to treating provider c. Retrain staff 7. Explore partnership with South Carolina Health Information Exchange (SCHIE) for Automated Data Transfer (ADT) feeds real time 8. Explore possibility of having provider HIE access to obtain discharge dates more real time. 5/1/20 - This is an ongoing process nearing completion 2ndd quarter 2020. All staff have been retrained to increase communication and documentation interdepartmentally. Leadership will meet monthly with teams to review documentation for accuracy. Monthly 1:1's with staff will be conducted to address deficiencies in process. Refer to attached work plan for details.	

In the 2020 file review for ATC, CCME noted an overall improvement in notifications of admissions and discharges between Utilization Management and Care Management staff,

and between ATC and the healthcare facilities. There were some areas found needing improvements. These included: reassessments not completed after a change in the member's status, clinical follow-up within 72 hours of the member's transition, outreach to the member's primary care physician, collaboration with the facilities discharge planner, and medication monitoring and adherence.

Molina's TOC file review conducted by CCME during the previous EQR found the clinical follow-up within 72 hours of discharge was either not found or did not occur within 72 hours of discharge. The files also lacked documentation, or the documentation was insufficient for other required elements. *Table 59: Previous Care Transitions QIP for Molina* notes those deficiencies and the actions Molina took to improve the transitions process.

Table 59: Previous Care Transitions QIP for Molina

STANDARD	EQR COMMENTS
III. Care Transitions	
1. The CICO conducts appropriate care transition functions, as defined by the CICO 3-Way Contract, Section 2.5 and 2.6, to minimize unnecessary complications related to care setting transitions.	CCME's reviewed of TOC files revealed a common issue related to the required clinical follow-up within 72 hours of discharge. In several files, the clinical follow-up with the member within 72 hours of discharge was either not found or did not occur within the required 72 hours. For several files, the progress notes submitted did not correlate to the dates of admission being reviewed. Additional common issues included lack of documentation, or insufficient documentation, of: •Date(s) of PCP notification of the member's admission. •Collaboration with the facility-based care managers/discharge planners. •Barriers to aftercare and strategies to address those barriers. •Medication monitoring. •Reassessments. Molina staff reported barriers that have been encountered include challenges with hiring qualified nurses and hospitals restricting TOC Coaches from visiting inpatient members to conduct face-to-face visits. Molina described several interventions that were continued or implemented during 2019 to address and improve care transition functions such as, but not limited to: •Staff training to improve TOC functions. •The addition of an administrative staff person to assist with admission and discharge notification to PCPs and internally among HCS staff. •Implementation of a new assessment tool.

STANDARD	EQR COMMENTS
	Quality Improvement Plan: Ensure all transition of care functions required by the CICO 3-Way Contract, Sections 2.5 and 2.6 are conducted and clearly documented in the member's file. This should include documentation of clinical follow-up within 72 hours of discharge, date(s) of PCP notification of the member's admission, collaboration with the facility-based care managers/discharge planners, identification of barriers to aftercare and strategies to address those barriers, medication monitoring, and required reassessments.
Molina Response: Following the onsite review, MMP Leadership reviewed both the electronic documentation in our Clinical Care Advance (Molina's Care Management System), as well as the PDF versions of CCME's selected cases. It became apparent that there were omissions in our file preparation. The team also identified several areas to improve file preparation that will capture more complete information in future audits. Our Improvement Plan includes the following activities and will be implemented by 6/30/20. 1) Update our existing 'MMP Transition of Care ("TOC") Workflow' to emphasize critical documentation elements needed as evidence of compliance. We will rename TOC progress note entries within our CCA system to make identification easier for file preparation. 2) Develop and implement an 'MMP TOC Compliance Checklist' that lists required elements that we will use in staff training and case auditing. 3) Monitor compliance by conducting real-time audits of all readmissions to identify documentation deficiencies, implement corrective measures and evaluate improvement opportunities. 4) Update the 'Chart Preparation Template' to ensure PDF documentation presented for CCME file submission includes all critical TOC compliance elements, including but not limited to clinical system entries having clearly visible dates 5) Update the MMP TOC Policy and Procedure to incorporate these quality improvement strategies and new processes for compliance surveillance.	

The 2021 review of Molina's TOC files reflected consistent collaboration and communication with PCPs and among HCS staff and timely communication of admission and discharge notifications among staff. Documentation of clinical follow-up within 72 hours was very clear and indicated when attempts were made to complete assessments when members could not be reached. As an improvement strategy in 2020, two staff roles were added to the TOC team to assist with clinical assessments and administrative tasks. Overall, TOC files reflect staff are providing appropriate services and meeting contract requirements.

The deficiencies found in the TOC file review for the 2020 EQR of Select Health are noted in *Table 60: Previous Care Transitions QIP for Select Health* with the CICO's response.

Table 60: Previous Care Transitions QIP for Select Health

STANDARD	EQR COMMENTS
III. Care Transitions	
1. The CICO conducts appropriate care transition functions, as defined by the CICO 3-Way Contract, Section 2.5 and 2.6, to minimize unnecessary complications related to care setting transitions.	CCME's review of care transitions files revealed consistent documentation of the point of contact at the health plan. However, the file review revealed the following issues: •Inconsistent documentation of collaboration with facility case management or discharge planning staff was noted in most of the files. •In most files, there was very little evidence of collaboration with the member's PCP when transitions occurred. •Clinical and non-clinical supports needed by the member were not clearly documented in most of the files. •Documentation of transition/aftercare appointments was lacking in most of the files. •Identification of barriers to after-care and strategies to address the barriers was identified in just over half of the files. •In more than half of the files it was noted the required 72-hour follow-up was either not conducted or was not conducted within the required timeframe. Some discharge dates were not identified, making it difficult to determine whether follow-up transition of care activities occurred within the required timeframes. •Most files contained no documentation of formal medication reconciliation and formal reassessment. One submitted file was eliminated from the review because it was determined there was no readmission for the member. *Quality Improvement Plan: Ensure all transition of care functions required by the CICO 3-Way Contract, Sections 2.5 and 2.6 are conducted and clearly documented in the member's file. This should include date(s) of PCP notification of the member's admission and discharge, collaboration with the facility-based care managers/discharge planners, identification of clinical and non-clinical supports needed by the member, documentation of transition/aftercare appointments, identification of barriers to aftercare and strategies to address those barriers, documentation of clinical follow-up within 72 hours of discharge, medication monitoring, and required reassessments.*
Select Health Response: 1. On June 30, 2020, we implemented a Transition of Care (TOC) Workgroup, which includes "Star" Care Coordinators. These Care Coordinators were identified as the top performers during recent chart audits for the External Quality Review Organization (EQRO). They will participate in the weekly TOC Workgroup with leadership to identify best practices. 2. The week of June 29, 2020, daily audits were implemented for Care Coordinators who were identified as the weakest during the EQRO audit and who also manage low risk members. Daily audits will allow these Care Coordinators to receive immediate feedback in time to be successful with the TOC.	

STANDARD	EQR COMMENTS
3. The daily inpatient/discharge report message was changed to the following, and will continue to be updated with additional pointers: •Remember to call within 72 hours of admission •Remember to update care plan - Place the TOC POC when you are notified of the admission and it can stay open the whole transition including for the 30 days after discharge to capture any work you do for the follow up appointments and such. Perfect place to put the interactions/interventions you are doing with the member •Remember to call within 72 hours of discharge 5. During the weekly meeting with the Care Coordinator "Stars", the following decisions were made: •Provide refresher training for this group so they can become TOC Subject Matter Experts (SME). This refresher training occurred on 8/4/20. •This group will start auditing the low-risk Care Coordinators and be paired with a small group to mentor them. •On 8/5/20 the low-risk Care Coordinators were informed that they would be paired with an experienced clinical Care Coordinator for training/mentoring. •Each of these trainers/mentors will conduct a training session with the small group assigned to them to include instruction on assessing for barriers and clinical and non-clinical supports that may be needed for a successful transition. In support of the clinical follow-up within 72 hours of discharge, associates will also receive medication reconciliation process and documentation training as well. This training began the week of 8/3/2020. •Audits for the rest of the Care Coordinators, who manage Moderate and High-Risk members, will be conducted as a group during the weekly TOC Stars meeting. Start Date: Week of 8/10/2020. •Conducting daily audits with the Community Health Navigators (CHNs), who initiate all of the activities for acute care admissions, will assist us in meeting the 72-hour requirements in real time, as opposed to the monthly audits conducted by the corporate auditing team. 6. Continued in place: The TOC Community Health Navigators (CHNs) under the Clinical Operations Supervisor will continue to meet regularly as a team and will continue to start the initial TOC for inpatient hospital admissions. The Supervisor will participate in the TOC Stars meeting to continue to work with her team as we strengthen the TOC process for inpatient hospital transitions, and transitions to and from skilled nursing facilities and rehabilitation and back to home, assisted living, or long-term nursing home placement. Daily auditing of the CHNs TOCs will start during the week of 8/10/2020. 7. Included in the follow-up training and auditing will be the following: •Collaborating with facility Case Manager/Discharge Planner •Collaborating with a member's primary care physician (PCP) – notifying PCP of both admission and discharge •Documentation of identified clinical and non-clinical supports needed •Documentation of follow-up appointments and times and any barriers which may impact scheduling the appointments •Document discharge dates •Completing and documenting that Medication Reconciliation has been completed •Evaluating if a Reassessment is indicated – which should be done for changes in condition or level of care that have a significant impact on the member •The week of 8/10/20 we will share a listing with our team that includes a list of primary contacts for Hospitals and Nursing Facilities in South Carolina. We will ensure this list has been updated with the best name/contacts for obtaining information and key facility individuals who can participate with discharge planning.	

STANDARD	EQR COMMENTS
8. Starting on 08/15/20 we will pilot one of our Care Coordinators working every Saturday to capture admissions/discharges sooner from our UM department to assist us further in meeting our 72-hour notification times.	

Select Health also implemented improvement strategies involving additional trainings, workgroups, and process improvement activities. The 2021 review of TOC files revealed an overall improvement in documentation. Specifically, files reflected consistent communications with the member's primary care physicians and timely notification of transitions between the utilization management and care management staff.

Documentation of clinical follow-up within 72 hours was clearly noted and reflected continued outreach attempts to complete assessments when members were not reached. However, CCME noted a major weakness in that the TOC files did not include documentation of a reassessment after a trigger event, such as a hospitalization or change in the member's status. Select Health submitted additional documents for six members; however, this requirement remained deficient (*SC CICO Three-Way Contract, Section 2.6.3.9)*.

Although Select Health collects data on member transitions at various levels of care, CCME could not determine if the data for transitions to higher levels of care was analyzed and discussed to evaluate for contributing factors or to identify improvement opportunities. During the onsite, Select Health could not confirm analysis of the data and indicated it will be included in quarterly Quality Assessment and Performance Improvement Committee (QAPI) meetings going forward.

Table 61: Care Transitions Comparative Data shows Molina improved their score and are meeting all the requirements in the Care Transitions section. ATC and Select Health continue to have deficiencies. The table indicates strengths, weaknesses, and recommendations related to quality, timeliness, and access to care.

Table 61: Care Transitions Comparative Data

Standard	ATC	Molina	Select	▶ = *Quality* ▶ = *Timeliness* ▶ = *Access to Care*
Care Transitions				
The CICO conducts appropriate care transition functions, as defined by the CICO 3-Way Contract, Section 2.5 and 2.6, to minimize unnecessary complications related to care setting transitions	Partially Met	Met ↑	Partially Met	**Strength:** ▶ All CICOs are monitoring the key indicators for evaluating over- and under-utilization **Weaknesses:** ▶ Select Health and ATC continue to have transition of care issues with reassessments and follow-up when a member transition occurs. ▶ Transitions that result in a move to a higher level of care are not analyzed to determine factors that contributed to the change and actions needed to improve outcomes. **Recommendations:** • Ensure all TOC functions required by the SCDHHS Contract, Sections 2.5 and 2.6 are conducted and clearly documented in the members' files. • CICOs should collect and analyze the data for transitions that result in a higher level of care to identify contributing factors and improvement opportunities.
Transitions that result in a move to a higher level of care are analyzed to determine factors that contributed to the change and actions taken by the CICO to improve outcomes	Met	Met	Not Met ↓	

D. Humana Healthy Horizons

CCME conducted a readiness review for Humana Healthy Horizons (Humana), a new MCO providing services for the Healthy Connections population in SC. This review was to assess the preparedness of Humana to enroll Medicaid beneficiaries as members in their MCO

and to provide the necessary and contractually required health care services to those members.

The objective of the review was to determine if Humana has the necessary administrative structure, staffing, policies and procedures, support services, provider availability, and member educational materials in place to: 1) commence enrollment, 2) deliver the contractually required services to members, and 3) prepare and submit contractually required reports to SCDHHS. The overriding goal of the Readiness Review process was to assure the contracted health care services can be delivered in a timely manner and will be of good quality.

The process CCME used for the Readiness Review is based on the protocols the Centers for Medicare & Medicaid Services (CMS) developed for Medicaid MCO External Quality Reviews (EQRs). The review included a desk review of documents and a two-day virtual onsite visit.

The EQR findings are summarized below and are based on the regulations set forth in *42 CFR Part 438 Subpart D*, the QAPI program requirements described in *42 CFR § 438.330*, and the contract requirements between Humana and SCDHHS. Areas of review were identified as meeting a standard ("Met"), acceptable but needing improvement ("Partially Met"), failing a standard ("Not Met"), "Not Applicable," or "Not Evaluated. Strengths, weaknesses, and recommendations are identified where applicable.

Administration

42 CFR § 438.242, 42 CFR § 457.1233 (d), 42 CFR § 438.224

Humana has in place written policies and procedures stating its commitment to compliance with applicable federal and state standards. Many of the policies reviewed contained wording directly from the *SCDHHS Contract* and did not specifically indicate Humana's processes for meeting the requirements. Many of the policies contained information related to Medicare or to other lines of business and were not specific to South Carolina. The procedure section of each policy should be reviewed to 1) expanded internal procedures or protocols, 2) outline steps currently in place, but not documented within existing policies, and 3) indicate steps that need to be taken internally to accomplish the intent of the Contract language as applicable.

Onsite discussion detailed the standards specific to Humana's organizational structure and staffing requirements. It was reported that key positions are in phases of recruitment with some offers of employment pending. The organizational chart outlines operational relationships for staff and lines of business collaboratively for Humana's South Carolina Market, Shared Services, and Medicaid Services roles. The Utilization Review Staff, Case

Management Staff, QI (Coordinator, Manager, Director), QAPI Staff, Member Services Manager, Medical Director, and the Board-Certified Psychiatrist/Psychologist are either currently vacant or do not meet the South Carolina residency requirements. Based on these findings, it appears Humana's personnel resources were not sufficient.

Humana's ISCA documentation and online resources confirm that data security is a priority. The documentation demonstrates adherence to best practices for both day-to-day staff operations and broader scenarios such as disaster planning. Additionally, Humana performs monitoring and auditing of the services they contract to business partners. In addition to regular training exercises, Humana's takes additional measures to update staff and keep them informed with regular security related emails, intranet articles, and a yearly cyber security awareness event.

The Humana Corporate Compliance Plan emphasizes the goal of creating a workplace environment in which ethics are an integral aspect of day-to-day operations. The Compliance Committee is Chaired by the Chief Compliance Officer and includes members who have decision-making authority and responsibility throughout the organization.

The Governance, Risk, and Compliance (GRC) Working Groups provide oversight of monitoring and auditing activities within Humana. This includes internal monitoring and audits, risk-based assessments and, as appropriate, external monitoring and auditing to evaluate Humana's compliance with state and federal requirements and the overall effectiveness of the Compliance Program. The SIU Anti-Fraud Plan details Humana's processes for detection, investigation, and prevention of suspected fraud and abuse for all lines of business.

Humana enforces South Carolina's Pharmacy Lock-In Program and tracks the frequency with which some drugs are filled, monitors the pharmacies where drugs are filled, and the number of doctor visits. In some cases, Humana may limit an enrollee to fill prescriptions at one pharmacy and from one doctor.

Humana associates, contractors, and vendors are governed by policies regarding all personal health information in accordance with the applicable federal and state laws, rules, and regulations. Training and support are provided to all Humana associates, subsidiaries, and affiliates.

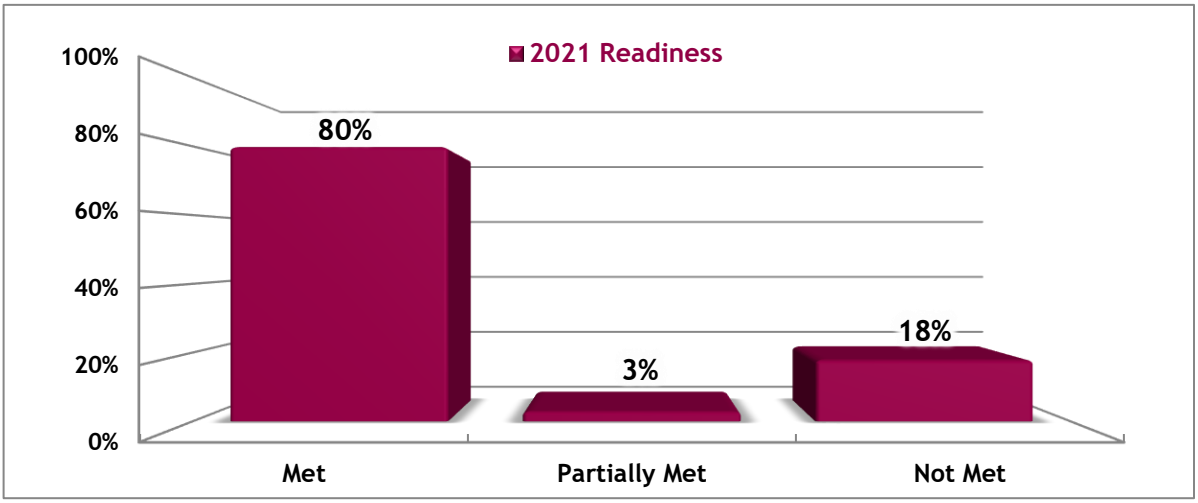
Information Systems Capabilities Assessment Review

Humana's ISCA documentation had a clear overview of systems, processes, and polices that are in place. The organization's security plan contains bolstered policies and procedures that address the tasks necessary to maintain that security posture. The plans have disaster recovery and business continuity plans to ensure its data and systems are

operational in the event of an outage. Policies and procedures aligned with *42 CFR § 438.242*, appear to be frequently reviewed and updated based upon each document's change log timestamps.

Figure 13: Administration Findings displays the scores for the Administration section of the review.

Figure 13: Administration Findings



Scores were rounded to the nearest whole number

Table 62: Administration Standards and Scores displays scores for individual standards as well as strengths, weaknesses, and recommendations related to quality, timeliness, and access to care.

Table 62: Administration Standards and Scores

Standard	Score	▶ = *Quality* ▶ = *Timeliness* ▶ = *Access to Care*
General Approach to Policies and Procedures		
The MCO has in place policies and procedures that impact the quality of care provided to members, both directly and indirectly	Partially Met	**Weaknesses:** ▶ While policies and procedures are in place, many of the policies and procedures only included the contract language directly from the *SCDHHS Contract* and did not specifically indicate Humana's process for addressing the requirements.

Standard	Score	▶ = *Quality* ▶ = *Timeliness* ▶ = *Access to Care*
		Recommendations: • Complete a comprehensive review of policies and procedures and add Humana's processes to accurately reflect steps currently in place or that need to be in place to demonstrate contract compliance.
Organizational Chart / Staffing		
The MCO's resources are sufficient to ensure that all health care products and services required by the State of South Carolina are provided to members. At a minimum, this includes designated staff performing in the following roles: *Administrator (Chief Executive Officer (CEO), Chief Operations Officer (COO), Executive Director (ED));	Met	**Weaknesses:** ▶ Humana's personnel resources are not sufficient—seven key positions are currently in phases of recruitment but are not filled. **Recommendations:** • Finalize the recruitment process to secure the seven current vacant key positions.
Chief Financial Officer (CFO)	Met	
*Contract Account Manager	Met	
Information Systems Personnel; Claims and Encounter Manager/ Administrator	Met	
Network Management Claims and Encounter Processing Staff	Met	
Utilization Management (Coordinator, Manager, Director);	Met	
Pharmacy Director	Met	
Utilization Review Staff	Not Met	
*Case Management Staff	Not Met	
*Quality Improvement (Coordinator, Manager, Director)	Not Met	
Quality Assessment and Performance Improvement Staff	Not Met	
*Provider Services Manager	Met	
*Provider Services Staff	Met	
*Member Services Manager	Not Met	
Member Services Staff	Met	
*Medical Director	Not Met	
*Compliance Officer	Met	

Standard	Score	▶ = *Quality* ▶ = *Timeliness* ▶ = *Access to Care*
Program Integrity Coordinator	Met	
Compliance /Program Integrity Staff	Met	
*Interagency Liaison	Met	
Legal Staff	Met	
Board Certified Psychiatrist or Psychologist	Not Met	
Post-payment Review Staff	Met	
Operational relationships of MCO staff are clearly delineated	Met	
Management Information Systems *42 CFR § 438.242, 42 CFR § 457.1233 (d)*		
The MCO processes provider claims in an accurate and timely fashion	Met	
The MCO is capable of accepting and generating HIPAA compliant electronic transactions	Met	
The MCO tracks enrollment and demographic data and links it to the provider base	Met	
The MCO's management information system is sufficient to support data reporting to the State and internally for MCO quality improvement and utilization monitoring activities	Met	
5. The MCO has policies, procedures and/or processes in place for addressing data security as required by the contract	Met	
The MCO has policies, procedures and/or processes in place for addressing system and information security and access management	Met	
The MCO has a disaster recovery and/or business continuity plan that has been tested, and the testing has been documented	Met	
Compliance/Program Integrity		
The MCO has a Compliance Plan to guard against fraud and abuse	Met	**Strengths:** ▶ Clear and easily accessible contact information is available to report fraud, waste, and abuse. ▶ The Ethics Every Day document provides examples of potential risks
The Compliance Plan and/or policies and procedures address all requirements	Met	
The MCO has an established committee responsible for oversight of the Compliance Program	Met	

Standard	Score	▶ = *Quality* ▶ = *Timeliness* ▶ = *Access to Care*
The MCO's policies and procedures define processes to prevent and detect potential or suspected fraud, waste, and abuse	Met	and practical measures to guard against ethics violations. ▶ Humana staff are provided with security information and updates in addition the organization's required security training.
The MCO's policies and procedures define how investigations of all reported incidents are conducted	Met	
The MCO has processes in place for provider payment suspensions and recoupments of overpayments	Met	
MCO implements and maintains a statewide Pharmacy Lock-In Program (SPLIP)	Met	
Confidentiality *42 CFR § 438.224*		
The MCO formulates and acts within written confidentiality policies and procedures that are consistent with state and federal regulations regarding health information privacy.	Met	

Provider Services

42 CFR § 10(h), 42 CFR § 438.206 through § 438.208, 42 CFR § 438.214, 42 CFR § 438.236, 42 CFR § 438.414, 42 CFR § 457.1230(a), 42 CFR § 457.1230(b), 42 CFR § 457.1230(c), 42 CFR § 457.1233(a), 42 CFR § 457.1233(c), 42 CFR § 457.1260

CCME's review of Provider Services included credentialing and recredentialing processes and a review of credentialing files, adequacy of the provider network, provider education, preventive health and clinical practice guidelines, continuity of care, and practitioner medical records.

Provider Credentialing and Selection

Humana follows NCQA credentialing standards and provided corporate policies and local health plan policy supplements documenting processes for initial credentialing and recredentialing. Humana staff verbalized that a 30 calendar-day timeframe will be followed for processing credentialing applications; however, the corporate credentialing policy referenced a 60 calendar-day timeframe, and the corresponding local plan policy did not document the timeframe followed. Humana's process and timeframe for reporting to SCDHHS any network providers or subcontractors that have been debarred, suspended, and/or excluded from participation in Medicaid, Medicare, or any other federal program could not be identified in any documents reviewed.

The *SCDHHS Policy and Procedure Guide for Managed Care Organizations, Section 2.8,* requires each MCO to maintain a Credentialing Committee for which the MCO's Medical

Director shall have overall responsibility. The Readiness Review revealed Humana did not have a local Credentialing Committee and there was no South Carolina representation on the Corporate Credentials Committee, which reviewed and made the final credentialing determination for the South Carolina provider network.

The review of initial credentialing files revealed various issues, including:

- Credentialing decision letters dated prior to the date of the Credentialing Committee's decision.
- Failure to collect formal collaborative agreement between the nurse practitioner and the supervising physician for all nurse practitioners.
- Failure to verify CLIA certificates for providers who indicated laboratory services are conducted in their offices and CLIA verifications conducted after the credentialing decision date.
- No evidence of attestation for most organizational providers.
- Failure to verify liability coverage for organizational providers.

Availability of Services

Humana's documented access requirements for PCPs, specialists, and hospitals were compliant with contractual requirements. The network is monitored and evaluated for adequacy via monthly Geo Access analytics, monthly adequacy reports which identify network gaps and activities to address gaps. Additional monitoring activities will include analysis of member satisfaction survey results, complaints/grievances, requests for out of network agreements, and Mystery Shopper Survey results. CCME could not identify the process for ensuring members have a choice of at least two contracted specialists accepting new patients within their geographic area.

The Humana Healthy Horizons in South Carolina Provider Support Plan (Network Development Plan) included the Medicaid Network Adequacy Report with data as of November 10, 2020. Compliance rates for several specialties were below the 90% benchmark, and Humana confirmed recruiting and contracting efforts were underway to increase the number of network providers of the applicable specialties.

Provider Education

Appropriate processes were identified for initial and ongoing provider training. In addition, Humana will utilize periodic provider newsletters, annual compliance training, updates in the online provider portal, mailings, faxes, and the Humana website to keep providers updated about the program.

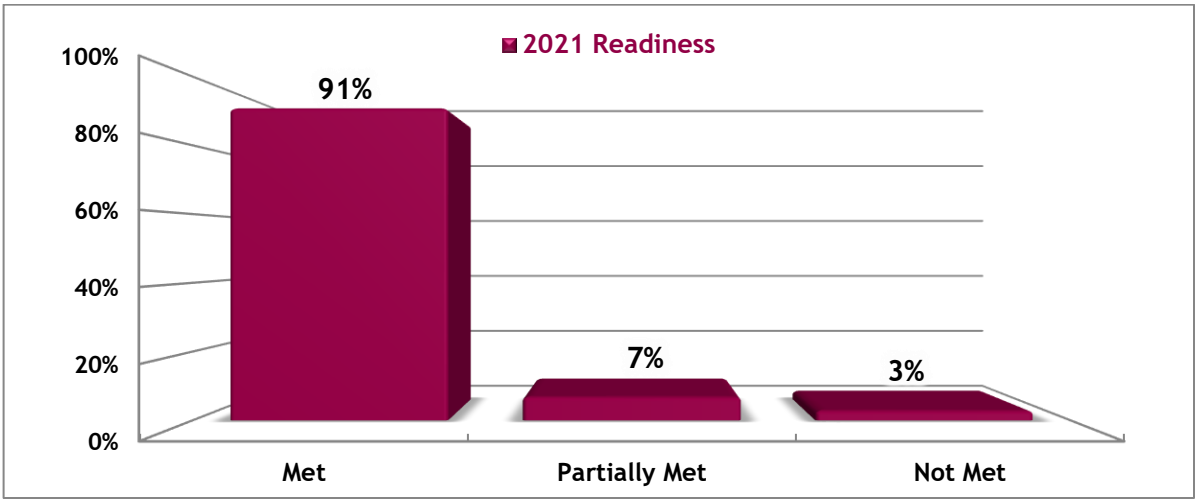
Humana's Healthy Horizons in South Carolina Quality Assessment and Performance Improvement Program Description (QI Program Description) addressed Culturally and Linguistically Appropriate Services (CLAS). Activities include identifying the ethnicity and racial make-up of membership; educating staff about cultural sensitivity and competency; providing member information in translated formats and through alternate telecommunications devices; and distributing cultural competency resources and training to providers. A link in the Provider Manual to access the Cultural Competency Plan on Humana's website did not take the user to the Cultural Competency Plan, and the plan could not be located elsewhere on the website.

Processes are in place for review and adoption of preventive health guidelines and clinical practice guidelines, and Humana posts the guidelines on its website. Information about the guidelines is included in the Provider Manual. Providers are educated about the guidelines and informed that provider implementation and use of the guidelines will be monitored. The Readiness Review revealed the guidelines did not include the American Academy of Pediatrics (AAP)/Bright Futures guidelines or any guidelines for Well Child Care other than a few specific screenings for children from the Prevention TaskForce. Humana acknowledged this finding and responded that Well Child Care guidelines will be approved and posted by July 1, 2021.

CCME could not identify in a policy or other document Humana's process for evaluating coordination of care between providers. Discussion during the onsite revealed a process had not been established.

Figure 14: Provider Services Findings displays the scores for the Provider Services section of the review.

Figure 14: Provider Services Findings



Scores were rounded to the nearest whole number

Table 63: Provider Services Standards and Scores displays scores for individual standards as well as strengths, weaknesses, and recommendations related to quality, timeliness, and access to care.

Table 63: Provider Services Standards and Scores

Standard	Score	▶ = *Quality* ▶ = *Timeliness* ▶ = *Access to Care*
Credentialing and Recredentialing *42 CFR § 438.214, 42 CFR § 457.1233(a)*		
The MCO formulates and acts within policies and procedures related to the credentialing and recredentialing of health care providers in a manner consistent with contractual requirements	Partially Met	**Weaknesses:** ▶ Policy (CORE Credentialing and Recredentialing)-001 did not indicate Humana will follow a 30-day timeframe for processing credentialing applications, as verbalized during the onsite. ▶ CCME could not identify a policy or other document that addressed the contractual requirement to report to SCDHHS any network providers or subcontractors that have been debarred, suspended, and/or excluded from participation in Medicaid, Medicare, or any other federal program immediately upon discovery.
Decisions regarding credentialing and recredentialing are made by a committee meeting at specified intervals and including peers of the applicant. Such decisions, if delegated, may be overridden by the MCO	Not Met	
The credentialing process includes all elements required by the contract and by the MCO's internal policies	Partially Met	
Verification of information on the applicant, including: Current valid license to practice in each state where the practitioner will treat members	Met	
Valid DEA certificate and/or CDS certificate	Met	

Standard	Score	▶ = *Quality* ▶ = *Timeliness* ▶ = *Access to Care*
Professional education and training, or board certification if claimed by the applicant	Met	▶ Humana did not have a local Credentialing Committee, as required by the SCDHHS Policy and Procedure Guide for Managed Care Organizations, Section 2.8. ▶ Credentialing file review revealed issues related to dates on credentialing determination letters, failure to collect formal collaborative agreements for nurse practitioners, failure to verify CLIA certificates and CLIA verifications conducted after the credentialing decision date, no evidence of attestation for most organizational providers, and failure to verify liability coverage for organizational providers. **Recommendations:** • Revise the "Policies and Procedures" section of Policy (CORE Credentialing and Recredentialing)-001 to indicate a 30-day timeframe will be followed for SC provider credentialing. • Revise an appropriate policy to define the process Humana will follow for reporting to SCDHHS any network providers that have been debarred, suspended, and/or excluded from participation in Medicaid, Medicare, or any other federal program immediately upon discovery. • Establish a local (plan level) Credentialing Committee to make credentialing determinations for the South Carolina provider network. Ensure the MCO Medical Director oversees and has overall responsibility for committee activities and that the committee includes network provider
Work history	Met	
Malpractice claims history	Met	
Formal application with attestation statement delineating any physical or mental health problem affecting ability to provide health care, any history of chemical dependency/ substance abuse, prior loss of license, prior felony convictions, loss or limitation of practice privileges or disciplinary action, the accuracy and completeness of the application	Met	
Query of the National Practitioner Data Bank (NPDB)	Met	
No debarred, suspended, or excluded from Federal procurement activities: Query of System for Award Management (SAM)	Met	
Query for state sanctions and/or license or DEA limitations (State Board of Examiners for the specific discipline)	Met	
Query of the State Excluded Provider's Report and the SC Providers Terminated for Cause List	Met	
Query for Medicare and/or Medicaid sanctions (5 years); OIG List of Excluded Individuals and Entities (LEIE)	Met	
Query of Social Security Administration's Death Master File (SSDMF)	Met	
Query of the National Plan and Provider Enumeration System (NPPES)	Met	
In good standing at the hospital designated by the provider as the primary admitting facility	Met	
Clinical Laboratory Improvement Amendment (CLIA) Certificate (or certificate of waiver) for providers billing laboratory procedures	Not Met	
Receipt of all elements prior to the credentialing decision, with no element older than 180 days	Met	
The recredentialing process includes all elements required by the contract and by the MCO's internal policies	Met	

Standard	Score	▶ = *Quality* ▶ = *Timeliness* ▶ = *Access to Care*
Recredentialing conducted at least every 36 months	Met	representation from various specialties, including mid-level practitioners. A committee charter should be developed to specify the committee's roles and responsibilities, membership, meeting frequency, quorum, attendance requirements, etc. • Ensure credentialing files contain evidence that credentialing determination letters are dated on or after the date of the credentialing determination. : • Ensure credentialing files for all nurse practitioners contain a copy of the current collaborative agreement between the nurse practitioner and the supervising physician. • Ensure credentialing files contain evidence of verification of the CLIA when the provider application indicates laboratory services are conducted in the provider's office/location, and that CLIA verification is conducted prior to the credentialing determination. • Ensure credentialing files contain attestation statements and verification of liability insurance for organizational providers.
Verification of information on the applicant, including: Current valid license to practice in each state where the practitioner will treat members	Met	
Valid DEA certificate and/or CDS certificate	Met	
Board certification if claimed by the applicant	Met	
Malpractice claims since the previous credentialing event	Met	
Practitioner attestation statement	Met	
Requery the National Practitioner Data Bank (NPDB)	Met	
Requery of System for Award Management (SAM)	Met	
Requery for state sanctions and/or license or DEA limitations (State Board of Examiners for the specific discipline)	Met	
Requery of the State Excluded Provider's Report and the SC Providers Terminated for Cause List	Met	
Requery for Medicare and/or Medicaid sanctions since the previous credentialing event; OIG List of Excluded Individuals and Entities (LEIE)	Met	
Query of the Social Security Administration's Death Master File (SSDMF)	Met	
Query of the National Plan and Provider Enumeration System (NPPES)	Met	
In good standing at the hospitals designated by the provider as the primary admitting facility	Met	
Clinical Laboratory Improvement Amendment (CLIA) Certificate for providers billing laboratory procedures	Met	
Review of practitioner profiling activities	Met	
The MCO formulates and acts within written policies and procedures for suspending or terminating a practitioner's affiliation with the MCO for serious quality of care or service issues	Met	

Standard	Score	▶ = *Quality* ▶ = *Timeliness* ▶ = *Access to Care*
Organizational providers with which the MCO contracts are accredited and/or licensed by appropriate authorities	Partially Met	
Monthly provider monitoring is conducted by the MCO to ensure providers are not prohibited from receiving Federal funds	Met	
Adequacy of the Provider Network *42 CFR § 438.206, 42 CFR § 438.207, 42 CFR § 10(h), 42 CFR § 457.1230(a), 42 CFR § 457.1230(b)*		
Members have a primary care physician located within a 30-mile radius of their residence	Met	**Strength:** ▶ The Corporate Bold Gold Initiative focuses on the impact of food insecurity and social isolation and captures the impact on healthy days in communities. **Weaknesses:** ▶ Humana's plan to ensure members have a choice of at least two contracted specialists who are accepting new patients within their geographic area was not identified. ▶ The Provider Manual included a link to view Humana's Cultural Competency Plan on the website, but the link was incorrect. The Humana Cultural Competency Plan was not located on the website by using the search functionality. **Recommendations:** • Revise an appropriate policy to address Humana's plan to ensure members have a choice of at least 2 contracted specialists who are accepting new patients within the members' geographic area. • Ensure the hyperlink to the Humana Cultural Competency Plan listed in the Provider Manual is correct and that the Humana Cultural Competency Plan is easily located on the website.
Members have access to specialty consultation from a network provider located within reasonable traveling distance of their homes. If a network specialist is not available, the member may utilize an out-of-network specialist with no benefit penalty	Met	
The sufficiency of the provider network in meeting membership demand is formally assessed at least bi-annually	Met	
Providers are available who can serve members with special needs such as hearing or vision impairment, foreign language/cultural requirements, and complex medical needs	Met	
The MCO demonstrates significant efforts to increase the provider network when it is identified as not meeting membership demand	Met	
The MCO maintains a provider directory that includes all requirements outlined in the contract	Partially Met	
Practitioner Accessibility *42 CFR § 438.206(c)(1), 42 CFR § 457.1230(a), 42 CFR § 457.1230(b)*		

Standard	Score	▶ = *Quality* ▶ = *Timeliness* ▶ = *Access to Care*
The MCO formulates and ensures that practitioners act within written policies and procedures that define acceptable access to practitioners and that are consistent with contract requirements.	Met	
Provider Education *42 CFR § 438.414, 42 CFR § 457.1260*		
The MCO formulates and acts within policies and procedures related to initial education of providers	Met	**Strength:** ▶ The Humana website includes the Cultural Competency Training 2021 document that provides information about culture and cultural competence, clear communication, various subcultures and populations, and strategies for working with seniors and people with disabilities.
Initial provider education includes: MCO structure and health care programs	Met	
Billing and reimbursement practices	Met	
Member benefits, including covered services, excluded services, and services provided under fee-for-service payment by SCDHHS	Met	
Procedure for referral to a specialist	Met	
Accessibility standards, including 24/7 access	Met	
Recommended standards of care	Met	
Medical record handling, availability, retention and confidentiality	Met	
Provider and member grievance and appeal procedures	Met	
Pharmacy policies and procedures necessary for making informed prescription choices	Met	
Reassignment of a member to another PCP	Met	
Medical record documentation requirements	Met	
The MCO provides ongoing education to providers regarding changes and/or additions to its programs, practices, member benefits, standards, policies and procedures	Met	
Primary and Secondary Preventive Health Guidelines *42 CFR § 438.236, 42 CFR § 457.1233(a)*		
The MCO develops preventive health guidelines for the care of its members that are consistent with national standards and covered benefits and that are periodically reviewed and/or updated	Met	**Weakness:** ▶ Humana's adopted preventive health guidelines did not include the AAP/Bright Futures guidelines or any guidelines for Well Child Care other than a few specific screenings for children from the
The MCO communicates the preventive health guidelines and the expectation that they will be followed for MCO members to providers	Met	

Standard	Score	▶ = *Quality* ▶ = *Timeliness* ▶ = *Access to Care*
The preventive health guidelines include, at a minimum, the following if relevant to member demographics: Well child care at specified intervals, including EPSDTs at State-mandated intervals	Met	Prevention TaskForce Preventive Care Recommendations. **Recommendations:** • Ensure Humana's approved preventive health guidelines include a guideline for Well Child Care screenings according to the AAP periodicity schedule, as required by the *SCDHHS Contract, Section 4.2.10.2*. The guideline should be included in Policy QM-001-17.
Recommended childhood immunizations	Met	
Pregnancy care	Met	
Adult screening recommendations at specified intervals	Met	
Elderly screening recommendations at specified intervals	Met	
Recommendations specific to member high-risk groups	Met	
Behavioral Health Services	Met	
Clinical Practice Guidelines for Disease, Chronic Illness Management, and Behavioral Health Services *42 CFR § 438.236, 42 CFR § 457.1233(a)*		
The MCO develops clinical practice guidelines for disease, chronic illness management, and behavioral health services of its members that are consistent with national or professional standards and covered benefits, are periodically reviewed and/or updated and are developed in conjunction with pertinent network specialists	Met	
The MCO communicates the clinical practice guidelines for disease, chronic illness management, and behavioral health services and the expectation that they will be followed for MCO members to providers	Met	
Continuity of Care *42 CFR § 438.208, 42 CFR § 457.1230(c)*		
The MCO monitors continuity and coordination of care between the PCPs and other providers	Partially Met	**Weakness:** ▶ The process for monitoring coordination of care between providers could not be identified program descriptions or in policies. Humana could not verbalize a process for this activity. **Recommendations:** • Document the process for monitoring coordination of care between providers in a policy, including methods of monitoring and assessment, processes for

Standard	Score	▶ = *Quality* ▶ = *Timeliness* ▶ = *Access to Care*
		addressing any identified deficiencies, etc.
Practitioner Medical Records		
The MCO formulates policies and procedures outlining standards for acceptable documentation in the member medical records maintained by primary care physicians	Met	
Standards for acceptable documentation in member medical records are consistent with contract requirements	Met	
The MCO monitors compliance with medical record documentation standards through periodic medical record audit and addresses any deficiencies with the providers	Met	
Accessibility to member medical records by the MCO for the purposes of quality improvement, utilization management, and/or other studies is contractually assured for a period of 5 years following expiration of the contract	Met	

Member Services

42 CFR § 438.56, 42 CFR § 1212, 42 CFR § 438.100, 42 CFR § 438.10, 42 CFR 457.1220, 42 CFR § 457.1207, 42 CFR § 438.3 (j), 42 CFR § 438. 228, 42 CFR § 438, Subpart F, 42 CFR § 457. 1260

CCME's review of Member Services focused on areas such as member rights and responsibilities, member education and informational materials, Member Satisfaction Surveys, and grievance procedures. The member-facing website was not launched at the time of this EQR thus, Member Services requirements for online access could not be reviewed. Humana has policies and procedures that define and describe Member Services activities and provide guidance to staff for performing those activities.

New members will receive a Welcome Kit that includes a welcome letter, a plan booklet providing an overview of benefits and services, instructions to access the Member Handbook and the Provider Directory, member education materials, and information about member rights. The Member Handbook provides key contact information, educates members about their rights and responsibilities, preventive health and appointment guidelines, and instructs members how to access benefits. However, EPSDT information in the Member Handbook is very brief. It does not provide a description of preventive exam components, the recommended age-appropriate exam intervals, or references to the

American Academy of Pediatrics (AAP) and Bright Futures Periodicity Schedule that can educate and assist members in obtaining these services.

CCME identified the discrepant information regarding copayments. Policy (UM- Core Benefits and Services)-007, indicates that copayments are allowed for members aged 19 and older, the Member Handbook reflect a pharmacy copayment of $3.40 applies to members 19 and older, and onsite discussions revealed that copayments are waived for all members of any age and for all covered benefits. Additionally, documentation of Humana's process for notifying members of changes in benefits or services could not be identified in the Member Handbook or other documents.

Humana will provide the Member Handbook in alternative formats upon request and ensures member program materials are written in a clear and understandable manner according to requirements in the *SCDHHS Contract, Section 3.15*. Materials and information can be accessed from the website, the member's portal, delivered via email, social media platforms, and free text messages. Additionally, Member Services staff will be available 8:00 a.m. to 6:00 p.m., Monday through Friday and the Nurse Advice Line is available 24 hours a day.

Policy HUM-SC-QM-007-01, Member Surveys, describes Humana's process for conducting, monitoring, and analyzing member surveys. However, it does not include the Children with Chronic Conditions version of the CAHPS survey.

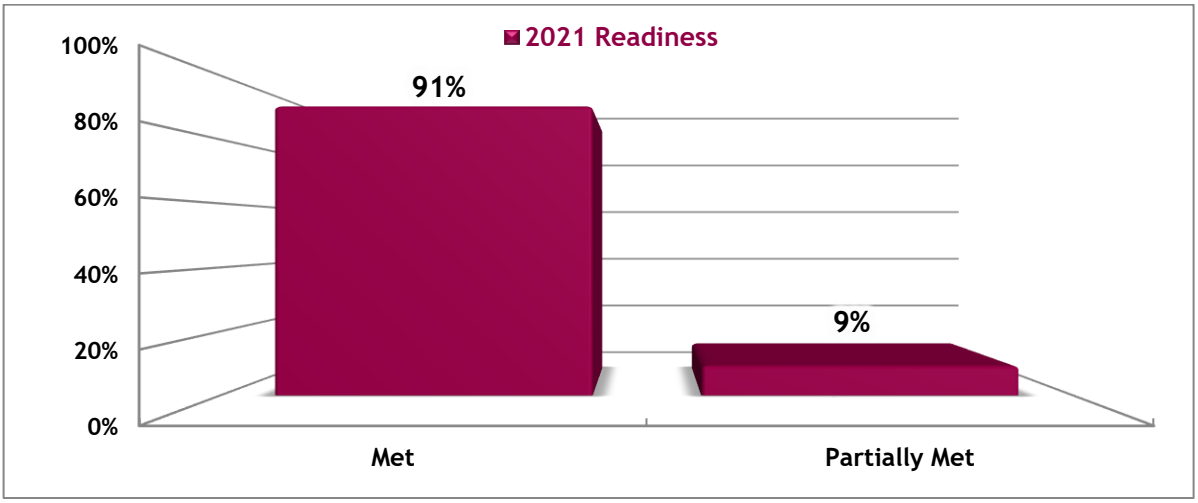
Grievances

42 CFR § 438. 228, 42 CFR § 438, Subpart F, 42 CFR § 457. 1260

CCME identified several documentation issues related to filing and handling grievances. Humana's staff confirmed and the Member Handbook indicates that Humana does not provide dental benefits to members and does not process grievances for dental services. However, the South Carolina Medicaid Grievance First Level Review-001F document and the South Carolina Medicaid First Level Review-Expedited Grievance -001C document indicates that Humana's grievance processes apply to medical and dental services. Documentation issues with omitting grievance acknowledgement timeframes and providing incorrect grievance filing timeframe were identified in policies and the Member Handbook listed conflicting contact information for grievance related services.

As noted in *Figure 15: Member Services Findings*, 91% of the standards for Member Services are scored as "Met" and 9% are scored as "Partially Met."

Figure 15: Member Services Findings



Scores were rounded to the nearest whole number

Table 64: Member Services Standards and Scores displays scores for individual standards as well as strengths, weaknesses, and recommendations related to quality, timeliness, and access to care.

Table 64: Member Services Standards and Scores

Standard	Score	▶ = *Quality* ▶ = *Timeliness* ▶ = *Access to Care*
Member Rights and Responsibilities *42 CFR § 438.100, 42 CFR § 457.1220*		
The MCO formulates and implements policies guaranteeing each member's rights and responsibilities and processes for informing members of their rights and responsibilities	Met	
All Member rights are included	Met	
Member MCO Program Education *42 CFR § 438.56, 42 CFR § 457.1212, 42 CFR § 438.3(j)*		
Members are informed in writing within 14 calendar days from the MCO's receipt of enrollment data of all benefits and MCO information	Partially Met	**Weaknesses:** ▶ Humana has waived copayments for all members for all covered benefits. However, Policy (UM-Core Benefits and Services)-007 indicates copayments are allowed for members aged 19 and older, and the Member Handbook
Members are notified at least once per year of their right to request a Member Handbook or Provider Directory	Met	
Members are informed in writing of changes in benefits and changes to the provider network	Partially Met	

Standard	Score	▶ = *Quality* ▶ = *Timeliness* ▶ = *Access to Care*
Member program education materials are written in a clear and understandable manner and meet contractual requirements	Met	mentions copayments for medications. ▶ Humana's process for notifying members of changes in benefits or services could not be identified in the Member Handbook or other documents. ▶ The Member Handbook has very limited information on EPSDT preventive services. **Recommendations:** • Edit the Member Handbook and Policy (UM- Core Benefits and Services)-007 to contain correct information about copayments. • In the Member Handbook, include Humana's process for notifying members of changes in benefits or services and include comprehensive information on EPSDT services.
The MCO maintains, and informs members how to access, a toll-free vehicle for 24-hour member access to coverage information from the MCO	Met	
Member Enrollment and Disenrollment *42 CFR § 438.56*		
The MCO enables each member to choose a PCP upon enrollment and provides assistance if needed	Met	**Strength:** ▶ Member materials and information can be accessed from the website and the online member portal, and delivered via email, social media platforms, and free text messages.
MCO-initiated member disenrollment requests are compliant with contractual requirements	Met	
Preventive Health and Chronic Disease Management Education		
The MCO informs members of available preventive health and disease management services and encourages members to utilize these services	Met	
The MCO tracks children eligible for recommended EPSDT services/immunizations and encourages members to utilize these benefits	Met	
The MCO provides education to members regarding health risk factors and wellness promotion	Met	
The MCO identifies pregnant members; provides educational information related to pregnancy, prepared childbirth, and	Met	

Standard	Score	▶ = *Quality* ▶ = *Timeliness* ▶ = *Access to Care*
parenting; and tracks the participation of pregnant members in recommended care		
Member Satisfaction Survey		
The MCO has a system in place to conduct a formal annual assessment of member satisfaction with MCO benefits and services. This assessment includes, but is not limited to	Met	**Weakness:** ▶ Policy (Member Surveys) HUM-SC-QM-007-01 does not include information for the Children with Chronic Conditions CAHPS survey. **Recommendations:** • Edit policy (Member Survey) HUM-SC-QM-007-01 to include information for the Children with Chronic Conditions version of the CAHPS survey.
Statistically sound methodology, including probability sampling to ensure it is representative of the total membership	Met	
The availability and accessibility of health care practitioners and services	Met	
The quality of health care received from MCO providers	Met	
The scope of benefits and services	Met	
Claim processing procedures	Met	
Adverse MCO claim decisions	Met	
The MCO analyzes data obtained from the member satisfaction survey to identify quality issues	Met	
The MCO implements significant measures to address quality issues identified through the member satisfaction survey	Met	
The MCO reports the results of the member satisfaction survey to providers	Met	
The MCO reports results of the member satisfaction survey and the impact of measures taken to address identified quality issues to the Quality Improvement Committee	Met	
Grievances *42 CFR § 438. 228, 42 CFR § 438, Subpart F, 42 CFR § 457. 1260*		
The MCO formulates reasonable policies and procedures for registering and responding to member grievances in a manner consistent with contract requirements, including, but not limited to	Met	**Weaknesses:** ▶ Humana does not process grievances for dental services. However, the South Carolina Medicaid Grievance First Level Review-001F document and the South Carolina Medicaid First Level Review-Expedited Grievance -001C document state, "This process applies to medical and dental."
The definition of a grievance and who may file a grievance	Met	
Procedures for filing and handling a grievance	Partially Met	
Timeliness guidelines for resolution of a grievance	Met	

Standard	Score	▶ = *Quality* ▶ = *Timeliness* ▶ = *Access to Care*
Review of grievances related to clinical issues or denial of expedited appeal resolution by a Medical Director or a physician designee	Met	▶ Grievance acknowledgment timeframes are not included in Policy (South Carolina Medicaid Grievance and Appeal Policy DRAFT)-001E. ▶ The grievance filing timeframe in the South Carolina Medicaid Grievance First Level Review-001F document is incorrect. ▶ The Member Handbook listed conflicting contact information for obtaining grievance related services. **Recommendations:** • Remove the references to dental service grievances from South Carolina Medicaid Grievance First Level Review-001F and South Carolina Medicaid First Level Review-Expedited Grievance - 001C. • Include grievance acknowledgment timeframes in Policy (South Carolina Medicaid Grievance and Appeal Policy DRAFT)-001E. • Correct the grievance filing timeframe in the South Carolina Medicaid Grievance First Level Review-001F document. • Edit the Member Handbook to correctly document the contact information for obtaining grievance related services.
Maintenance and retention of a grievance log and grievance records for the period specified in the contract	Met	
Grievances are tallied, categorized, analyzed for patterns and potential quality improvement opportunities, and reported to the Quality Improvement Committee	Met	
Grievances are managed in accordance with the MCO confidentiality policies and procedures	Met	

Quality Improvement

42 CFR §438.330 and 42 CFR §457.1240(b)

Humana provided the Healthy Horizons in South Carolina Quality Assessment and Performance Improvement Program Description, 2021 and a copy of the Quality Improvement (QI) work plan template and several QI policies. The program description provided the goals and objectives for the QI program; however, it did not address the scope of the program or include details regarding the utilization data Humana plans to monitor.

The Quality Assurance Committee (QAC) is the local committee responsible for the development and implementation of Humana's QI program in South Carolina. Humana's South Carolina Medicaid Medical Director will chair the QAC. Voting members include Humana's executives, medical and quality directors, and other managers. Medical and behavioral health network providers will be included as non-voting members. It is recommended Humana consider including the network providers as voting members of the QAC.

Humana provided a sample of the 2021 Quality Assessment and Performance Improvement Program work plan. The sample work plan included the activities, objectives, goals, responsible parties, and the frequency or timeframe for completion of activities. The work plan will be updated as needed and annually at a minimum.

Humana will use the Stars Quality Report, which includes a list of members that have a known gap in care. This report is delivered to network providers via in-person visits, self-service access to a provider reporting system, mail, and secure fax. Physician performance will be monitored according to policy (NNO 702-040 Physician Performance Measurement)-007. However, this policy only addressed the Medicare Advantage line of business.

Performance Measure Validation

42 CFR §438.330 (c) and §457.1240 (b)

Humana's policy (Performance Measures)-005 (HUM-SC-QM-005-01) provides the process for collecting and reporting performance data. Performance data will be collected through a combination of various sources such as surveys, medical records, and claims or encounter data. Humana contracts with an NCQA-licensed organization to conduct the HEDIS audit. On page four of this policy, under letter E, it incorrectly states, "All HEDIS, Health Outcomes Survey and CAHPS data will be reported consistent with Medicare requirements. All existing Part D metrics will be collected." This policy should be corrected and include the Medicaid requirements for collecting performance measures.

Performance Improvement Project Validation

42 CFR §438.330 (d) and §457.1240 (b)

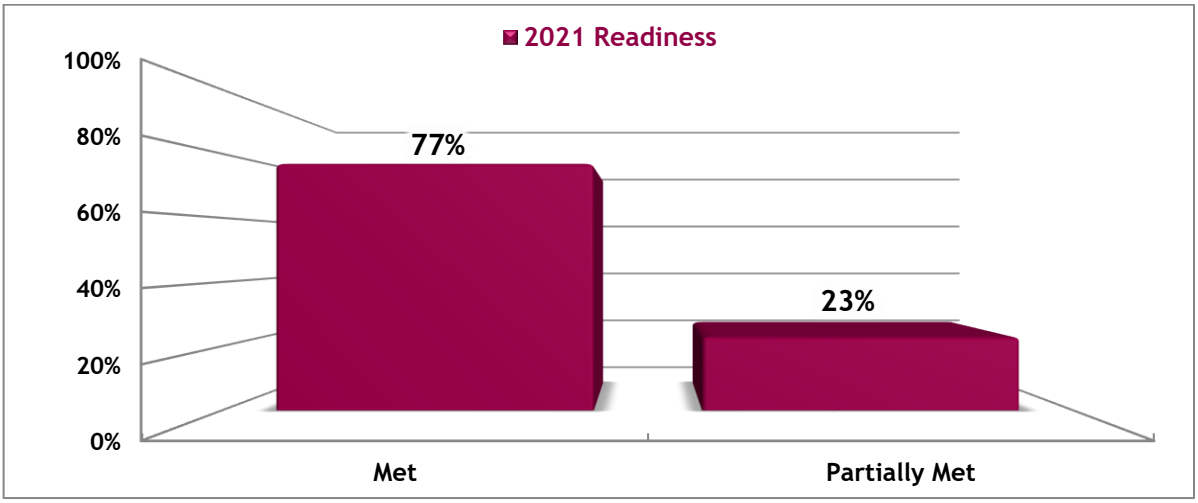
The materials submitted by Humana lacked details regarding how the performance improvement projects will be handled. The QI Program Description contains a paragraph on page 42 titled, "Performance Improvement Projects." However, this section only included the State's expectations for performance improvement projects. Humana has a policy, (PIP) HUM-SC-MCD-QM-002-01, that only includes roles and responsibilities. This policy mentions the Quality Director will work with Medicaid and Quality Improvement

leadership to develop meaningful topics that consider the prevalence of a condition in the member population. This policy fails to include the details of how the performance improvement project topics are developed or selected, what potential data will be used, and the steps needed for approval of the project.

Humana provided the Performance Improvement Project template as an example of how performance improvement projects will be documented. This template meets the requirements, however CCME provided a few recommendations. Page six contained the barriers and interventions to address any barriers. CCME recommends separating the interventions and barriers documentation and identify the type of intervention (provider, member, system etc.). This allows for better documentation of improvement strategies, ongoing strategies, and changes in the strategy. The CMS protocol requires documentation of statistical evidence. Humana should include a section in the Performance Improvement Project template that addresses statistical testing and presents the p-values from the tests.

For this Readiness Review, Humana received a "Met" score for 77% of the standards in the Quality Improvement section. The Partially Met scores were related to documentation in the QI Program Description, the Performance Improvement Project policy, and the Physician Performance Measurement policy.

Figure 16: Quality Improvement Findings



Scores were rounded to the nearest whole number

Table 65: Quality Improvement Standards and Scores displays scores for individual standards as well as strengths, weaknesses, and recommendations related to quality, timeliness, and access to care.

Table 65: Quality Improvement Standards and Scores

Standard	Score	▶ = *Quality* ▶ = *Timeliness* ▶ = *Access to Care*
The Quality Improvement (QI) Program *42 CFR §438.330 (a)(b) and 42 CFR §457.1240(b)*		
The MCO has a system in place for implementing a formal quality improvement program with clearly defined goals, structure, scope and methodology directed at improving the quality of health care delivered to members	Met	**Strength:** ▶ Humana provided a sample of the 2021 Quality Assessment and Performance Improvement Program work plan. The sample work plan included all requirements and will be updated as needed. **Weakness:** ▶ The QI Program Description does not address the scope of the program and does not include details regarding the data Humana plans to monitor for potential over and underutilization issues. **Recommendation:** • Update the QI Program documents to address the scope of the program and details regarding the data used to monitor over- and under-utilization.
The scope of the QI program includes investigation of trends noted through utilization data collection and analysis that demonstrate potential health care delivery problems	Met	
An annual plan of QI activities is in place which includes areas to be studied, follow up of previous projects where appropriate, timeframe for implementation and completion, and the person(s) responsible for the project(s)	Met	
Quality Improvement Committee		
The MCO has established a committee charged with oversight of the QI program, with clearly delineated responsibilities	Met	**Weakness:** ▶ Medical and behavioral health network providers will not be included as voting members on the Quality Assurance Committee. **Recommendation:** • Network providers invited to participate in the QI program should be included as voting members on the quality committees.
The composition of the QI Committee reflects the membership required by the contract	Met	
The QI Committee meets at regular quarterly intervals	Met	
Minutes will be maintained that document proceedings of the QI Committee	Met	
Performance Measures *42 CFR §438.330 (c) and §457.1240 (b)*		
The process for collecting and reporting the performance measures are consistent with the requirements of the contract	Met	
Quality Improvement Projects *42 CFR §438.330 (d) and §457.1240 (b)*		

Standard	Score	▶ = *Quality* ▶ = *Timeliness* ▶ = *Access to Care*
Topics selected for study under the QI program are chosen from problems and/or needs pertinent to the member population	Partially Met	**Weakness:** ▶ The materials submitted by Humana lacked details regarding how the performance improvement projects will be handled. **Recommendations:** • Update the performance improvement project template to include evidence of the statistical testing if sampling is used, separate the interventions and barriers documentation, and include the type of intervention.
The study design for QI projects meets the requirements of the CMS protocol "Validating Performance Improvement Projects"	Met	
Provider Participation in Quality Improvement Activities		
The MCO requires its providers to actively participate in QI activities	Met	**Weakness:** ▶ Policies did not include the specific process for monitoring South Carolina Medicaid provider performance. **Recommendations:** • Update the QI Program documents to address details regarding monitoring provider performance.
Providers will receive interpretation of their QI performance data and feedback regarding QI activities	Partially Met	
Annual Evaluation of the Quality Improvement Program *42 CFR §438.330 (e)(2) and §457.1240 (b)*		
A written summary and assessment of the effectiveness of the QI program will be prepared annually and submitted to the QI Committee and to the MCO Board of Directors	Met	

Utilization Management

42 CFR § 438.210(a-e),42 CFR § 440.230, 42 CFR § 438.114, 42 CFR § 457.1230 (d), 42 CFR § 457. 1228, 42 CFR § 438.228,42 CFR § 438, Subpart F, 42 CFR § 457. 1260, 42 CFR § 208, 42 CFR § 457.1230 (c),42 CFR § 208, 42 CFR § 457.1230 (c)

CCME's review of Humana's Utilization Management Program included UM policies and procedures, medical necessity determination processes, pharmacy requirements, and the Care Management Program. The UM Program Description and policies will provide guidance to staff conducting UM activities for physical health, behavioral health, and pharmaceutical services for members in South Carolina.

Medical necessity reviews of service authorization requests will be conducted by appropriate staff, using guidelines from Milliman Care Guidelines (MCG), SC Medicaid manuals, medical coverage policies, and guidelines from the American Society of Addiction Medicine (ASAM).

The Member Handbook and Provider Manual has minimal information for hysterectomies, sterilizations, and abortions and Humana does not have a policy or process for handling requests for hysterectomies, sterilizations, and abortions. The UM Program Description describes emergency services but does not include a description of post stabilization services.

The Care Management Program Description describes Humana's approach to providing Care Management; however, processes for providing Targeted Care Management services were not noted in the Care Management Program Description or any other document. Additionally, Humana has not designated a Transition Coordinator and reported recruitment efforts are in progress.

Although Humana submitted the Fraud, Research, Analytics and Concepts (FRAC) document, a UM Data Plan, and a UM Program Description support Humana's approach for evaluating over and under-utilization, these documents did not include a defined timeline for utilization data analysis, specific areas of interest (readmission, ER rates, pharmacy, etc.), who will set target rates, who will assist with monitoring and interventions, and plans to mitigate when issues are identified.

Appeals

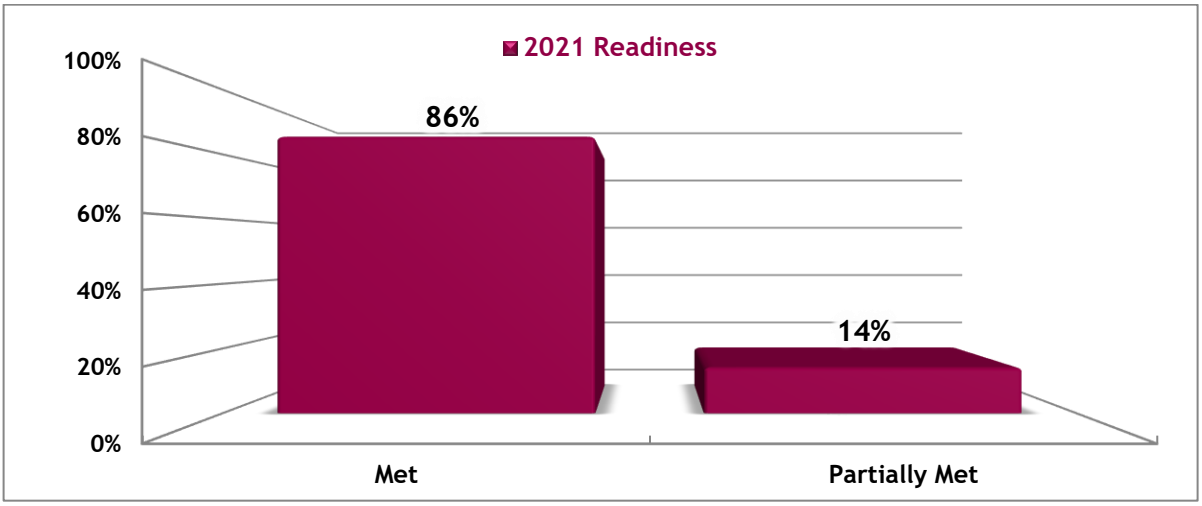
42 CFR § 438.228,42 CFR § 438, Subpart F, 42 CFR § 457.1260

Documentation in policies indicate appeal determinations will be conducted and resolution notices will be provided within 30 calendar days of receipt for standard appeals and within 72 hours of receipt for expedited appeals. Determination letter templates include contractually required information and instructions will be written in language that can be easily understood by a layperson.

Documentation in the UM Program Description and policies indicate that Humana provides and reviews appeals for dental services. However, Humana staff confirmed that the plan does not provide dental benefits to members and does not handle appeals or service authorizations for dental services. It was advised that documents are updated to clarify and or correct the misinformation.

As noted in *Figure 17: Utilization Management Findings*, Humana achieved "Met" scores for 86% of the Utilization Management standards.

Figure 17: Utilization Management Findings



Scores were rounded to the nearest whole number

Table 66: Utilization Management Standards and Scores displays scores for individual standards as well as strengths, weaknesses, and recommendations related to quality, timeliness, and access to care.

Table 66: Utilization Management Standards and Scores

Standard	Score	▶ = *Quality* ▶ = *Timeliness* ▶ = *Access to Care*
The Utilization Management (UM) Program		
The MCO has in place policies and procedures that describe its utilization management program, including but not limited to	Met	**Weaknesses:** ▶ The UM Program does not have oversight from a Medical Director and Behavioral Health Medical Director. Humana reported recruitment efforts are in progress. ▶ Although Humana staff indicated the Medical Management Committee (MMC) includes network providers, documentation in the UM Program Description and QI Program Description do not indicate providers from the network are members of the MMC.
structure of the program and methodology used to evaluate the medical necessity	Met	
lines of responsibility and accountability	Met	
guidelines / standards to be used in making utilization management decisions	Met	
timeliness of UM decisions, initial notification, and written (or electronic) verification	Met	
consideration of new technology	Met	
the absence of direct financial incentives or established quotas to provider or UM staff for denials of coverage or services	Met	
the mechanism to provide for a preferred provider program	Met	

Standard	Score	▶ = *Quality* ▶ = *Timeliness* ▶ = *Access to Care*
Utilization management activities will occur within significant oversight by the Medical Director or the Medical Director's physician designee	Met	**Recommendations:** • Continue recruitment efforts to fill the Medical Director and Behavioral Health Medical Director positions. • Include in a document, such as the UM Program Description, QI Program Description, and SC Committee Charters, that participating network providers with various medical disciplines are included as members of the committee(s) responsible for overseeing UM activities.
The UM program design will be periodically reevaluated, including practitioner input on medical necessity determination guidelines and grievances and/or appeals related to medical necessity and coverage decisions	Met	
Medical Necessity Determinations *42 CFR § 438.210(a-e),42 CFR § 440.230, 42 CFR § 438.114, 42 CFR § 457.1230 (d), 42 CFR § 457. 1228*		
Utilization management standards/criteria to be used are in place for determining medical necessity for all covered benefit situations	Met	**Strength:** ▶ Determination letter templates are written in language that is easily understood by a layperson. **Weaknesses:** ▶ The Member Handbook and Provider Manual do not include that service authorization decision timeframes can be extended by 14 days when requested by the member or plan. ▶ The Member Handbook and Provider Manual information about coverage of hysterectomies, sterilizations, and abortions is limited and does not include the specific requirements for coverage. ▶ Humana does not have a policy defining processes and requirements coverage of hysterectomies, sterilizations, and abortions. ▶ The UM Program Description does not include a description of post stabilization services. **Recommendations:** • Include information about extensions of service authorization determination timeframes in the
Utilization management decisions will be made using predetermined standards/criteria and all available medical information	Met	
Coverage of hysterectomies, sterilizations and abortions is consistent with state and federal regulations	Partially Met	
Utilization management standards/criteria are reasonable and allow for unique individual patient decisions	Met	
Utilization management standards/criteria will be consistently applied to all members across all reviewers	Met	
Pharmacy Requirements Any pharmacy formulary restrictions are reasonable and are made in consultation with pharmaceutical experts.	Met	
If the MCO uses a closed formulary, there is a mechanism for making exceptions based on medical necessity	Met	
Emergency and post stabilization care will be provided in a manner consistent with the contract and federal regulations	Met	
Utilization management standards/criteria are available to providers	Met	
Utilization management decisions will be made by appropriately trained reviewers	Met	

Standard	Score	▶ = *Quality* ▶ = *Timeliness* ▶ = *Access to Care*
Initial utilization decisions will be made promptly after all necessary information is received	Met	Member Handbook and Provider Manual. • Update the information in the Member Handbook and Provider Manual regarding coverage of hysterectomies, sterilizations, and abortions. • Develop and document in a policy Humana's processes for handling hysterectomies, sterilizations, and abortions. • Include a description for post stabilization services in the UM Program Description.
Denials		
A reasonable effort that is not burdensome on the member or the provider will be made to obtain all pertinent information prior to making the decision to deny services	Met	
All decisions to deny services based on medical necessity will be reviewed by an appropriate physician specialist	Met	
Denial decisions will be promptly communicated to the provider and member and include the basis for the denial of service and the procedure for appeal	Met	
Appeals *42 CFR § 438.228, 42 CFR § 438, Subpart F, 42 CFR § 457. 1260*		
The MCO has in place policies and procedures for registering and responding to member and/or provider appeals of an adverse benefit determination by the MCO in a manner consistent with contract requirements, including	Met	**Strength:** ▶ The Member Handbook instructs that a signed Authorization of Representative form is needed for a provider or another person to act on a member's behalf. **Weakness:** ▶ The terms "appeal" is not completely and clearly defined in the Key Words and Appeals sections of the Member Handbook and the term "adverse benefit determination" is not defined in the Member Handbook. ▶ Policy South Carolina Medicaid Standard Appeal First Level-001G and Policy South Carolina-Medicaid Expedited Appeal First Level-001B use the terms "notice of action" and "adverse determination notice" instead of "adverse benefit determination notice" or "notice of adverse benefit determination." ▶ Page 3 of Policy (South Carolina Medicaid Standard Appeal First Level)-001G refers to Kentucky Medicaid.
The definitions of an adverse benefit determination and an appeal and who may file an appeal	Partially Met	
The procedure for filing an appeal	Partially Met	
Review of any appeal involving medical necessity or clinical issues, including examination of all original medical information as well as any new information, by a practitioner with the appropriate medical expertise who has not previously reviewed the case	Met	
A mechanism for expedited appeal where the life or health of the member would be jeopardized by delay	Met	
Timeliness guidelines for resolution of the appeal as specified in the contract	Partially Met	
Written notice of the appeal resolution as required by the contract	Met	

Standard	Score	▶ = *Quality* ▶ = *Timeliness* ▶ = *Access to Care*
Other requirements as specified in the contract	Met	▶ Policy (South Carolina Medicaid Standard Appeal First Level)-001G incorrectly indicates the appeals process outlined includes dental services. ▶ Policy South Carolina Medicaid Standard Appeal First Level-001G and Policy South Carolina Medicaid Expedited Appeal First Level-001B do not include the requirement to provide members with assistance in completing appeal forms and procedures. ▶ Policy South Carolina Medicaid Standard Appeal First Level-001G, Policy South Carolina Medicaid Expedited Appeal First Level-001B, the Provider Manual, and the Appeal Acknowledgement Letter do not: address requirements to provide members the opportunity to present evidence related to the appeal, inform members of the limited time to present evidence prior to the appeal resolution, and inform members they can examine the appeal case file before and during the appeal process. ▶ Policy Medicaid Standard Appeal First Level-001G does not include the requirement that notice of appeal resolution must be provided within 30 days of receipt of the appeal. ▶ Policy (Medicaid Expedited Appeal First Level)-001B does not include the requirement to inform members that they may file a grievance if a request for an expedited appeal is denied. **Recommendation:** • Edit the Member Handbook to correctly define the term “appeal and to define the term “adverse benefit determination.”
Appeals are tallied, categorized, analyzed for patterns and potential quality improvement opportunities, and reported to the Quality Improvement Committee	Met	
Appeals are managed in accordance with the MCO confidentiality policies and procedures	Met	

Standard	Score	▶ = *Quality* ▶ = *Timeliness* ▶ = *Access to Care*
		• Edit Policy South Carolina Medicaid Standard Appeal First Level-001G and Policy South Carolina Medicaid Expedited Appeal First Level-001B to use the terms "adverse benefit determination notice" or "notice of adverse benefit determination" and include the requirement that Humana will provide assistance with appeals procedures. • Remove the reference to Kentucky Medicaid from Policy (South Carolina Medicaid Grievance and Appeal Policy DRAFT)-001E. • Revise Policy (South Carolina Medicaid Standard Appeal First Level)-001G to remove the reference to dental appeals. • Edit Policy South Carolina Medicaid Standard Appeal First Level-001G, Policy South Carolina Medicaid Expedited Appeal First Level-001B, the Provider Manual, and the Appeal Acknowledgement Letter to address requirements for providing members the opportunity to present evidence related to their appeal, informing members of the limited time available to do so, and informing members they can examine their appeal case file. • Revise Policy (South Carolina Medicaid Standard Appeal First Level)-001G to include the requirement that the notice of the appeal resolution the must be provided within 30 days of receipt of the appeal. • In Policy (Medicaid Expedited Appeal First Level)-001B, include that Humana will inform members of the right to file a grievance if the member disagrees with a denial of expedited appeal processing.

Standard	Score	▶ = *Quality* ▶ = *Timeliness* ▶ = *Access to Care*
		• Edit Policy (South Carolina Medicaid Standard Appeal First Level)-001G and Policy (South Carolina Medicaid Expedited Appeal First Level)-001B to include that members have 120 days from the date on the appeal resolution notice to request a State Fair Hearing.
Care Management and Coordination *42 CFR § 208, 42 CFR § 457.1230 (c)*		
The MCO formulates policies and procedures that describe its case management/care coordination programs	Met	**Weaknesses:** ▶ CCME could not identify Humana's process for ensuring Targeted Care Management services are provided. The Care Management Program Description does not define or describe Targeted Care Management or identify the population to receive these services. ▶ A Transition Coordinator has not been designated. Humana staff explained recruitment efforts are in progress. **Recommendations:** • Define and describe, in a program description or other document, Humana's process for ensuring Targeted Care Management services are provided to the population specified in the SCDHHS Contract, Section 4.2.27. • Continue recruitment efforts for a Transition Coordinator.
The MCO has processes to identify members who may benefit from case management	Met	
The MCO provides care management activities based on the member's risk stratification	Met	
The MCO utilizes care management techniques to ensure comprehensive, coordinated care for all members	Partially Met	
Care Transitions activities include all contractually required components. The MCO has developed and implemented policies and procedures that address transition of care	Met	
The MCO has a designated Transition Coordinator who meets contract requirements	Met	
The MCO measures case management performance and member satisfaction, and has processes to improve performance when necessary	Met	
Evaluation of Over/ Underutilization		
The MCO has mechanisms to detect and document under-utilization and over-utilization of medical services as required by the contract	Partially Met	**Weakness:** ▶ The process or plan for how Humana will detect and monitor over-and under-utilization was incomplete. **Recommendations:** • Develop a plan or process for how Humana will monitor over and underutilization.

Delegation

42 CFR § 438.230 and 42 CFR § 457.1233(b)

CCME's review of Delegation included the submitted Delegate List, delegation agreements, and delegation monitoring materials.

Humana has delegation agreements with the entities displayed in *Table 67: Delegated Entities and Services*.

Table 67: Delegated Entities and Services

Delegated Entities	Delegated Services
•National Medical Review (NMR) •FOCUS Health, Inc.	Utilization Review
•AnMed Health •Carolina Family Health Inc/MUSC Physicians PCP •St Francis Physician Services/Bon Secours Medical Group •United Physicians, Inc.	Credentialing
•Superior Vision Benefit Manager, Inc.	Vision Benefit Management
•Infomedia Group, Inc. dba Carenet Healthcare Services	24/7 Nurse Advice Line

As noted in the Subcontractor Monitoring and Oversight Plan and in Policy (Delegation)-001, Humana retains accountability for each delegated service and monitors the performance of delegated entities. A pre-delegation review is conducted to assess each entity's program, associated policies and procedures, staffing capabilities, and performance record prior to the entity performing the delegated activity. Humana will conduct annual oversight monitoring for each delegated entity to determine whether delegated activities are being carried out as required.

The Delegation Policy attached to Policy (Delegation)-001 defines processes for delegation approval and states the Delegated Services Addendum and Delegation Attachment must: be executed for each delegated function; describe the activities and the responsibilities of Humana and the Delegated Entity; require at least semiannual reporting; describe how Humana evaluates the delegated entity's performance; and describe the remedies available if the delegate does not fulfill its obligations. However, the policy does not fully address requirements for sub-delegation. It fails to include that SCDHHS must receive prior notification of any further delegation by a subcontractor. Also, the policy addresses checking the OIG and SAM during the pre-delegation assessment but does not address the queries on an ongoing basis as required by the *SCDHHS Contract, Section 2.5.13*.

As indicated in *Figure 18: Delegation Findings*, 50% of the standards in the Delegation section were scored as "Met."

Figure 18: Delegation Findings

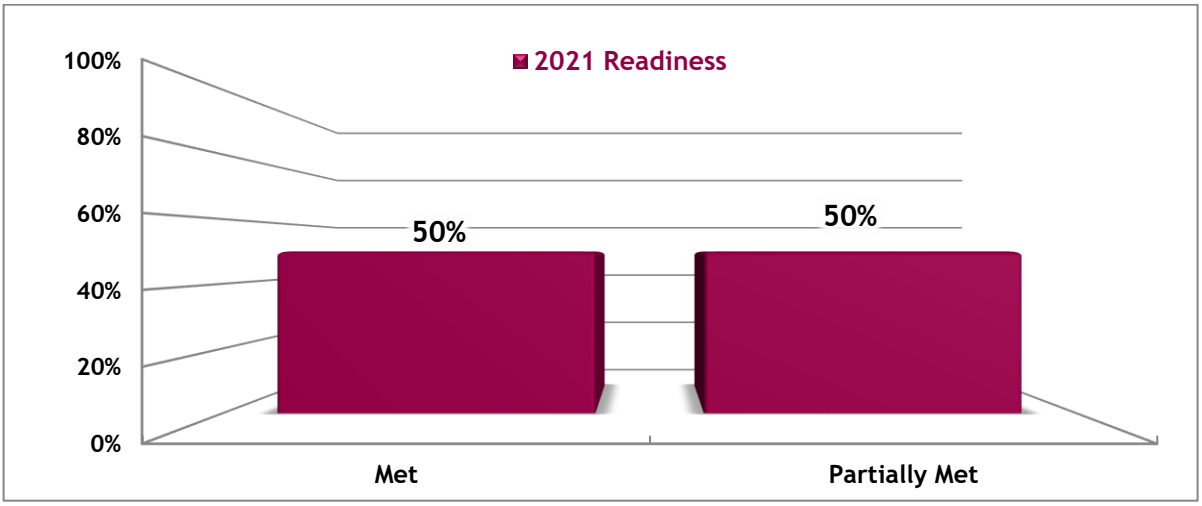


Table 68: Delegation Standards and Scores displays scores for individual standards as well as strengths, weaknesses, and recommendations related to quality, timeliness, and access to care.

Table 68: Delegation Standards and Scores

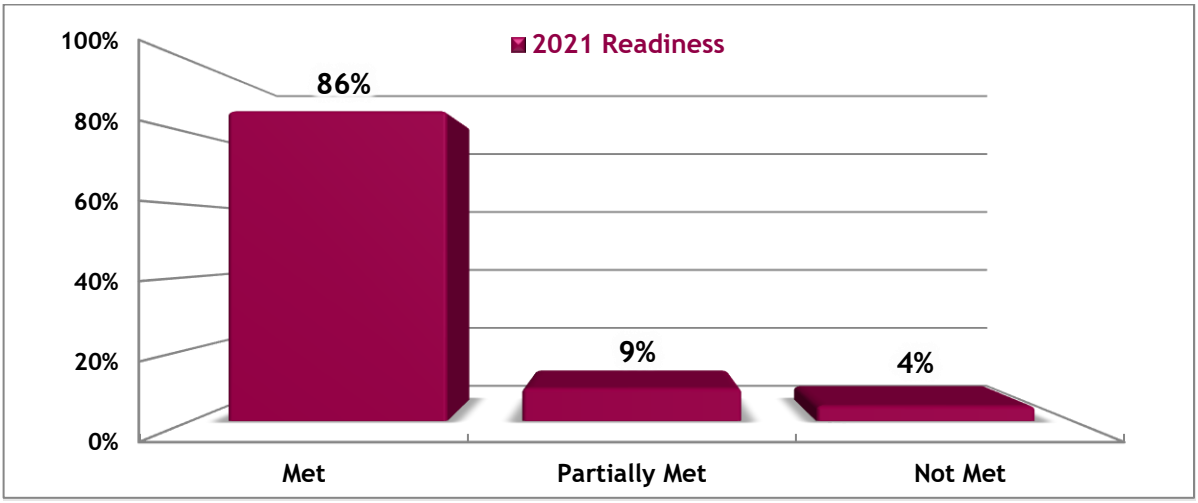
Standard	Score	▶ = *Quality* ▶ = *Timeliness* ▶ = *Access to Care*
DELEGATION *42 CFR § 438.230 and 42 CFR § 457.1233(b)*		
The MCO has written agreements with all contractors or agencies performing delegated functions that outline responsibilities of the contractor or agency in performing those delegated functions	Met	**Weaknesses:** ▶ Multiple sections in the Delegation Policy attached to Policy (Delegation)-001 address sub-delegation but do not address the requirement that SCDHHS must receive prior notification of any further delegation by a subcontractor. ▶ The Delegation Policy addresses checking the OIG and SAM during the pre-delegation assessment but does not address the queries on an ongoing basis.
The MCO conducts oversight of all delegated functions sufficient to ensure that such functions are performed using those standards that would apply to the MCO if the MCO were directly performing the delegated functions	Partially Met	

Standard	Score	▶ = *Quality* ▶ = *Timeliness* ▶ = *Access to Care*
		Recommendation: • Revise the Delegation Policy attached to Policy (Delegation)-001 to include the requirement that SCDHHS must receive prior notification of any further delegation by a subcontractor and to include requirements for checking the OIG and SAM on an ongoing basis.

Conclusions

Overall, there were issues with Humana's staffing and credentialing processes that did not meet the requirements set forth in *42 CFR Part 438 Subpart D* and the QAPI program requirements described in *42 CFR § 438.330* and the *SCDHHS Contract*. In the Readiness Review, Humana achieved "Met" scores for 86% of the standards reviewed. As the following chart indicates, 9% of the standards were scored as "Partially Met," and 4% of the standards scored as "Not Met."

Figure 19: Readiness Review Overall Results



Scores were rounded to the nearest whole number

FINDINGS SUMMARY

Overall, ATC, Molina, and WellCare sustained or showed the most improvements in six areas followed by Healthy Blue in four areas. *Table 69: Annual Review Comparisons* reflects the total percentage of standards scored as "Met" for the 2020 through 2021 EQR. The percentages highlighted in green indicate an improvement over the prior review findings. Those highlighted in yellow represent a reduction in the prior review findings. Areas reviewed for the MCOs that are not applicable for Solutions is noted as Not Applicable (NA). Humana was not included in this chart since the review conducted in 2021 was a readiness review.

Table 69: Annual Review Comparisons

	ATC		HEALTHY BLUE		MOLINA		SELECT HEALTH		SOLUTIONS		WELLCARE	
	2019	2020	2020	2021	2020	2021	2019	2020	2020	2021	2020	2021
Administration	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	95%	100%
Provider Services	92%	99%	96%	96%	100%	96%	99%	95%	100%	100%	94%	95%
Member Services	97%	100%	94%	100%	97%	100%	100%	97%	NA	NA	88%	100%
Quality Improvement	100%	100%	100%	100%	86%	93%	100%	100%	100%	100%	100%	100%
*Utilization Management	98%	100%	98%	100%	98%	100%	100%	98%	100%	93%	89%	98%
Delegation	100%	100%	50%	50%	100%	100%	50%	50%	NA	NA	50%	50%
State Mandated Services	100%	75%	100%	75%	75%	100%	100%	75%	NA	NA	75%	100%

*Care Coordination/Case Management for Solutions